Portraits of patients and sufferers in Britain, c. 1660-c. 1850

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Portraits of patients and sufferers in Britain, c. 1660-c. 1850

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DHJ

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Contents

Abbreviations

BL – British Library, London

BM – British Museum, London

DNB – Oxford Dictionary of National Biography; http://odnb.org

NLS – National Library of Scotland, Edinburgh

NPG – National Portrait Gallery, London

OED – Oxford English Dictionary

PMC – Paul Mellon Centre for Studies in British Art, London

RCPE – Royal College of Physicians, Edinburgh

RCPL – Royal College of Physicians, London

RCSEng – Royal College of Surgeons of England

WL – Wellcome Library, London

Note on the text

As I mention in the Introduction below, the list of *dramatis personae* is very long. Accordingly, I have not seen fit to include the dates of everyone mentioned, but only of those discussed in some detail. Unless elaborated on, the masculine implies the feminine as well. Where relevant, dates before 1752 are referred to in both the Old and New Style. Original spellings and punctuation have been retained in quotations, save for where they have been pulled from modern editions that have amended them.

List of Figures

Figure 21: Bedford Armorial ware, 1815, Wedgwood Museum, Barlaston.

Figure 22: G. Stubbs, *Wedgwood and his family* (details).

Figure 23: J. Wedgwood, *Elizabeth Montagu*, 1775, jasper relief medallion, 41 x 33 x 10mm.

Figure 24: G. Stubbs, *Josiah Wedgwood*, 1780, oil on ceramic, 505 x 395mm.

Figure 25: M. Dahl, *Queen Anne*, 1705, oil on canvas, 2368 x 1448mm.

Figure 26: A. Ramsay (studio), *King George III,* 1761-2, oil on canvas, 1473mm x 1067mm.

Figure 27: W. Beechey, *King George III*, 1799-1800, oil on canvas, 2337mm x 1448mm.

Figure 28: F. Bartolozzi, after W. Hamilton, *On the General Illumination of his Majesty's Recovery,* 1790, mezzotint, 468 x 530mm.

Figure 29: Anon., *The Triumph of Hygeia,* 1789, mezzotint, 365 x 238mm.

Figure 30: S. W. Reynolds, *George III,* 1820, mezzotint, 405 x 295mm.

Figure 31: S. W. Reynolds, *George III* (proof), 1820, mezzotint, 280 x 223mm

Figure 32: T. Lawrence, *George Canning* (detail), 1826, oil on canvas, 2385 x 1472mm.

Figure 33: T. Phillips, *Sir Francis Leggatt Chantrey,* 1818, oil on panel, 914 x 772mm.

Figure 34: S. W. Reynolds, *George III,* 1820, mezzotint, 405 x 295mm.

Figure 35: C. Turner, *King George the Third When Blind,* 1820, mezzotint/stipple/etching, 365 x 253mm.

Figure 36: A. Ramsay, *Study of hands for the portraits of George III (as Prince of Wales)...,* 1757, red chalk on paper, 310 x 230mm.

Figure 37: J. C. Stadler, *His Majesty at Cheltenham Spa,* 1819, aquatint with watercolour, 282 x 246mm.

Figure 38: G. Dance, *Untitled*, n.d., pencil on paper, 241 x 826mm.

Figure 39: S. Ireland, after W. Hogarth, *Characters who frequented Button's Coffee-house about the year 1730*, 1786, etching, 163 x 202mm.

Figure 40: J. Bretherton, after C. L. Smith*, A Sunday Concert*, 1782, etching and aquatint, 357 x 491mm.

Figure 41: F. Bartolozzi (after), *Monument to Thomas Guy*, 1779, line engraving, 419 x 274mm.

Figure 42: A. Ramsay, *William Hunter,* c. 1764-5,oil on canvas, 960 x 750mm.

Figure 43: Frontispiece to R. Burton, *The Anatomy of Melancholy* (London, 1652).

Figure 44: G. White, after G. Kneller, *Mr Pope*, n.d., mezzotint, 201 x 150mm.

Figure 45: J. Houbraken, after A. Pond, *Alexander Pope*, 1747, line engraving, 350 x 216mm.

Figure 46: J. Reynolds, *Horace Walpole*, 1756-7, oil on canvas, 1272 x 1018mm.

Figure 47: C. F. von Breda, *James Watt*, 1792, oil on canvas 1257 x 1003mm.

Figure 48: J. Reynolds, *Lawrence Sterne*, 1760, oil on canvas, 1273 x 1003mm.

Figure 49: C. Bowles, after J. Russell, *Selina Hastings, Countess of Huntingdon*, 1773, mezzotint, 502 x 353mm.

Figure 50: Anon., *Selina Hastings, Countess of Huntingdon*, n.d. (c. 1780s), oil on card, 565 x 438mm.

Figure 51: J. Fittler, after R. Bowyer, *Selina Hastings, Dowager of Huntingdon*, 1790, line engraving, 255 x 197mm (plate).

Figure 52: G. (Lord) Townshend, *The Boot & the Block-Head*, 1762, etching, 287 x 198mm.

Figure 53: C. Williams, *John Bull contemplating a statue of Portland stone*, 1807, etching, 253 x 360mm.

Figure 54: J. Zoffany, *John and Mary Wilkes*, 1782, oil on canvas, 1264 x 1003mm.

Figure 55: Anon., *Francis Trouille: The Horned Man*, 1814, etching, 180 x 120mm.

Figure 56: Anon., *Francis Trovillou: The Horned Man*, n.d., stipple, 153 x 97mm.

Figure 57: W. Baillie after N. Hone, *Jas Turner a Beggar...*, 1774, etching, 81 x 70mm (plate).

Figure 58: N. Edelink, *Charles de Saint Evremond*, line engraving, c. 1700, 194 x 149mm.

Figure 59: G. Duckett, *His Holiness and his Prime Minister*, 1729, etching, 337mm x 210mm.

Figure 60: Frontispiece to *Ingratitude; to Mr Pope...,* (London, 1733); separate etching on paper, c. 1733, 99mm x 75mm.

Figure 61: J. Richardson, *Mr Pope*, 1738, etching, 147 x 114mm.

Figure 62: J. Stow, after A. Pond, *Alex. Pope*, 1794, stipple and etching, 313 x 211mm.

Figure 63: Frontispiece to *The Works of William Hay, Esq*.... (London, 1794).

Figure 64: J. Reynolds (attrib.), *William Hay*, n.d., oil on canvas, 743 x 616mm; and detail.

Figure 65: J. Kay, *Untitled*, 1802, etching, in Paterson, *A Series of Original Portraits and Caricature Etchings* (Edinburgh, 2 vols., 1878), i, 329.

Figure 66: S. W. Fores (pub.), *The Natty, Lad or Polish, Dwarf taking an airing*, 1787, etching, 248 x 172mm.

Figure 67: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious account of his birth, education, marriage, travels and voyages; written by himself* (trans. Des Carrieres, London, 1788).

Figure 68: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious account of his birth, education, marriage, travels and voyages; written by himself* (trans. Des Carrieres, London, 1788).

Figure 69: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious Account of his birth, education, marriage, travels and voyages; written by himself* , *and carefully revised and corrected* (trans. S. Freeman, Birmingham, 1795).

Figure 70: Frontispiece to J. Boruwlaski, *Memoirs of Count Boruwlaski* (Durham, 1820).

Figure 71: P. Reinagle, *Josef Boruwlaski*, n.d., oil on canvas, 1360 x 1080mm.

Figure 72: S. Percy, Josef Boruwlaski, 1798, wax amulet, 187 x 162mm.

Figure 73: J. Zoffany, *William Hunter Teaching Anatomy at the Royal Academy*, c. 1772, oil on canvas, 774 x 1035mm.

Figure 74: W. Bell, *John Burley*, 1785, ink and watercolour on paper, RCSEng HDB/4/2/387/1.

Figure 75: W. Bell, *John Burley*, 1785, ink and watercolour on paper, RCSEng HDB/4/2/387/2.

Figure 76: W. Bell, *Miss Miller*, 1781, graphite on paper, RCSEng HDB/3/1/857/1.

Figure 77: J. Rymsdyk, *Jonathan Burn*, 1755, watercolour on paper, RCSEng HDB/4/2/405/1.

Figure 78: J. Rymsdyk, *Jonathan Burn*, 1755, watercolour on paper, RCSEng HDB/4/2/406/1.

Figure 79: J. Hunter, *Hydrocephalus* [of Jonathan Burn], 1755, graphite on paper, RCSEng HDB/4/2/407/2.

Figure 80: J. Rymsdyk, *Jonathan Burn*, 1755, graphite on paper and watercolour on paper, RCSEng HDB/4/2/407/1.

Figure 81: W. Bell, *Thomas Norman*, 1785, graphite on paper, RCSEng HDB/4/2/410/1.

Figure 82: surviving preparation from Norman's case, RCSEng RCSHC/P /154.

Figure 83: surviving preparation from Norman's case, RCSEng RCSHC/P /155.

Figure 84: surviving preparation from Norman's case, RCSEng RCSHC/P /156.

Figure85: surviving preparation from Norman's case, RCSEng RCSHC/P /1186.

Figure 86: Bailey, after Beaumont, *No. 1*, n.d., ink and graphite on paper, RCSEng HDB/3/1/843A/1.

Figure 87: Bailey, after Beaumont, *No. 2*, n.d., ink and graphite on paper, RCSEng HDB/3/1/843A 2.

Figure 88: R. Cheston, *James Jones*, 1779, graphite on paper, RCSEng HDB/4/2/390/1.

Figure 89: J. Basire after K.(?) Rickelts, *No. 1*, 1780, line engraving, in *Philosophical Transactions of the Royal Society*, 52, plate XIII.

Figure 90: T. Reichel, *Peruntaloo*, 1787, graphite and ink on paper, RCSEng HDB/3/1/845/1.

Figures 91-95: RCSEng MS0008/4/5/5, ff. 794ff.

Figure 96: Anon., *John Adams*, n.d., watercolour and oil on paper, RCSEng MS0008/4/5/6, f. 319r.

Figure 97: Anon., *Joseph Silvester Aet 73...,* n.d., graphite and watercolour on paper, RCSEng MS0008/4/4, f. 1.

Figure 98: Anon., *Cancer of ye Upper Lip* [of Joseph Marner], n.d., graphite and watercolour on paper, RCSEng MS0008/4/4, ff. 242-3.

Figure 99: Anon., *Andrew Griffin Aet 3*, RCSEng MS0008/4/4, ff. 40-1.

Figure 100: Anon., *Disease of ye Popliteal Nerve* [of Mrs Dodd(s?)], RCSEng MS008/4/5/3, f. 390r.

Figure 101: Anon., *Cancer* [of William Fox], RCSEng MS008/4/5/8, f. 505.

Figure 102: Anon., *Untitled*, RCSEng MS 0008/4/5/6, f. 317r.

Figure 103: RCSEng MS0008/4/5/3, ff. 103ff.

Figure 104: J. Thomson, *François Chapuis,* 1815, pen and ink on paper, *Sketches,* f. 31.

Figure 105: J. Thomson, *Alexander Kirkland,* 1815, pen and ink on paper, *Sketches* f. 26.

Figure 106: J. Thomson, *Joseph Holleran,* 1815, pen and ink on paper, *Sketches,* f. 31.

Figure 107: J. Thomson, *Sanges*, 1815, pen and ink on paper, *Sketches*, f. 56.

Figure 108: J. Thomson, *William Ryan*, 1815, pen and ink on paper, *Sketches*, f. 43.

Figure 109: J. Thomson, *Froctront*; 1815, pen and ink on paper, *Sketches,* f. 37.

Figure 110: J. Thomson, *James Young*, 1815, pen and ink on paper, *Sketches*, f. 24.

Figure 111: S. Nicholls, Untitled [*Margaret White*], 1740, line engraving, from W. Cheselden, *Anatomy of the Human Body*, pl. 40.

Figure 112: S. Nicholls, Untitled [J*ohn Heysham*], 1740, line engraving, from W. Cheselden, *Anatomy of the Human Body*, pl. 39.

Figure 113: M. Burghers, *Elizabeth Hopkins*, c. 1700, line engraving, 72 x 63mm.

Figure 114: M. Burghers*, Mrs John Webb*, c. 1700, line engraving, 72 x 63mm.

Figure 115: J. Rogers, after R. E. Drummond, *Miss Hannah Thatcher*, 1823, stipple, 219 x 141mm.

Figure 116: J. Wales, after W. Nutter, *A Singular Operation*, 1795, stipple, 364 x 248mm.

Figure 117: Leonard, after R. W. Bradley, *Elizabeth Powis*, 1845, lithograph, frontispiece to E. Sands Cox, *A Memoir on Amputation at the Hip-Joint.*

Figures 118-121: A. Rochard, *Couser Dinner*, n.d., graphite on paper, MOR/4/34-5,

reprinted W. H. Lizars, in A. Morison and T. C. Morison, *Outlines* 1848, pl. 7-8.

Figure 122: F. Rochard, *W Hanwell*, n.d., graphite on paper, MOR/4/90.

Figure 123: W. Fairland (?), *Mrs Redditch aet. 72 / Emphysema Bronchitis*, n.d., pen on card, 533 x 399mm, RCPL SIBSF/793/122.

Figure 124: From F. Sibson, *Medical Anatomy*, plate XII.

Figure 125: From F. Sibson, *Medical Anatomy*, plate XVI.

Figure 126: W. Fairland (?), *Untitled* [Thomas Dedin], n.d., pen and watercolour on card, 716 x 526mm, RCPL SIBSF/793/189.

Figure 127: From F. Sibson*, Medical Anatomy*, plate I (detail).

Figure 128: From F. Sibson, *Medical Anatomy*, plate III; and detail.

Figure 129: W. Fairland (?), *Syl. Redgate. Rheumatic Pericarditis. Pericardial Effusi [on]/ Gradual & Complete Absorption of Fluid*, n.d., watercolour on card, 705 x 517mm, RCPL SIBSF/793/217.

Figure 130: J. Smith, after G. Kneller, *Johannes Smith*, 1716, mezzotint, 340 x 255mm.

Figure 131: W. Allan, *William Hey, with a child patient* [and Lady Harewood], 1816, oil on canvas.

Figure 132: J. Preud'homme, *Douglas, 8th Duke Hamilton, on His Grand Tour with his Physician Dr John Moore and the Latter's Son, John*, 1773, oil on canvas, 970 x 750mm.

Figure 133: J. Richardson, *Alexander Pope*, 1738, oil on canvas, 441 x 365mm.

Figure 134: J. Richardson, *Martin Folkes*, 1735, graphite on vellum, 179 x 134mm.

Figure 135: J. Richardson, *Hans Sloane*, 1740, pen and ink, over graphite, on vellum, 177 x 130mm.

Figure 136: J. Richardson, *Alexander Pope*, 1733/4, graphite on vellum, 168 x 136mm.

Figure 137: J. Richardson, *William Cheselden*, 1735, pen and ink, over graphite, on vellum, 144 x 90mm.

Figure 138: J.-A. Dassier, *Alexander Pope / Poeta Anglus MDCCXLI*, 1741, bronze, 55mm. (copper copy).

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Abstract

Portraits of sufferers and patients in the long eighteenth century have been understudied – especially by comparison with portraits of doctors and other visual imagery that supposedly illuminates long eighteenth-century medical history. Yet these portraits – and the art historical methods used to analyse them – yield important new insights into the social history of medicine of this period. Such portraits were used to convey how identity was affected by illness. They were the means for debating contemporary standards of bodily judgment and character perception. In clinical settings, they were the means for doctors to analyse and compare cases. They also recorded what diseases looked like, in doing so shaping how doctors conceived of diseases and patients' identity. In publications, portraits of sufferers and patients inscribed the medical knowledge that doctors sought to disseminate by embodying 'expert' visual skills. Finally, in wider cultural contexts, they expressed what was medical about the relationships that contemporaries conducted. These findings propel the histories not only of patients and 'suffering', but also of doctors and medical relationships – four key concerns of recent scholarship.

The thesis stresses the specificity of portraiture. Portraits are analysed on their own terms alongside other visual and textual sources. This method complements the way contemporaries were 'interdisciplinary' as a matter of course. Meanwhile, focussing on portraiture – at once a mediating process, a technology and a genre of art – allows themes of agency, knowledge, power and representation to be intertwined. Moreover, instead of focussing attention only on doctors and patients (as people as well as medical categories), portraits reveal that medical agency is distributed between all those whose interests were at stake and advanced by the making and seeing of such portraits. Finally, this study suggests ways of setting up *longue-durée* comparisons between different forms of representation across different periods.

Introduction

This thesis examines portraits of patients and sufferers in the long eighteenth century. Such portraits constitute a hitherto unexplored intersection between art and medicine in this period. My main goal is to show how these portraits are rich and high-yielding sources for investigating the social and cultural history of long eighteenth-century medicine.

Debates, themes and questions

Historians have been interested in the historical overlap between art and medicine for many years. Charting it has occasioned many debates and highlighted several salient issues in the history of medicine. Four historiographies in particular have prompted the questions that propel this thesis.

Medical portraiture

The most immediate and specific historiographical impulse for this thesis is the previous narrow uses of the phrase 'medical portraiture'. Concerning the long eighteenth century, medical portraiture has become a catch-phrase for portraits of *doctors*. Historians have looked at how doctors exploited portraits as public-relations tools, primarily to efface unwanted perceptions and generate new ones. Ludmilla Jordanova, Aris Sarifianos and the cataloguers of the portraits of the pre-eminent contemporary medical institutions have all argued that portraits played some active role in shaping how doctors wanted to present themselves (cf. chap. II).[1] Portraits helped to celebrate pioneering doctors, for instance – a

[1] L. J. Jordanova, *Defining Features: Medical and Scientific Portraits, 1660-2000* (London, 2000); A. Sarafianos, 'The Natural History of Man and the Politics of Medical Portraiture in Manchester', *Art Bulletin*, 88, 1 (2006), 102-18; D. Piper, 'Take the face of a physician', in G. Wolstenholme and J. F. Kerslake, *The Royal College of Physicians of London: Portraits Catalogue II* (Amsterdam, Oxford and New York, 1977), 25-49; G. Wolstenholme

point typified by (Dr) Thomas Pettigrew's *Medical Portrait Gallery...of the most celebrated physicians* (1840).

However, as far as the eighteenth century is concerned, there is little conceptual or empirical justification for confining the phrase 'medical portraiture' to portraits of doctors. Indeed, in other periods, particularly in later nineteenth- and twentieth-century contexts, portraits of patients have repaid close scrutiny and careful theoretical framing. Portraits of the patients of Jean-Martin Charcot, Hugh Diamond and Harold Gillies, for instance, have illuminated contemporary medical practices and sensibilities. Indeed, such portraits have even advanced our understanding of these doctors as well as their patients.[2] Yet despite these examples, no-one has paid sustained attention to portraits of patients in Britain in the long eighteenth century.

There are three particular lacunae that this neglect has generated. First, we have asked about the effect of portraiture on doctors' identities, but not about how patients' and sufferers' identities were affected by being portrayed as well as being ill. Second, if doctors' portraits were 'in dialogue' with cultural concerns, which affected how doctors were seen, then we can increase our understanding of the putative role of medical portraiture by asking how patients' portraits were also in conversation with contemporary cultural concerns (like the interest in 'curiosity', for instance – see chap. II). Third, if historians of other periods are quite used to inferring important clues about doctors from patients' portraits, it is open to ask what such portraits can tell us about the actual thinking and working of long eighteenth-century doctors, too.

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and D. Piper, *The Royal College of Physicians of London's Portraits* (London, 1964); Wolstenholme and Kerslake; *Royal College of Physicians*.

[2] S. Gilman, 'Lam Qua and the development of westernized medical iconography in China', *Medical History*, 30, 1 (1986), 57-69; L. N. Heinrich, *The afterlife of images: translating the pathological body between China and the West* (Durham, 2008), ch. 2; S. Biernoff, 'Flesh Poems: Henry Tonks and the Art of Surgery', *Visual Culture in Britain*, 11, 1 (2010), 25-48; E. Chambers, 'Fragmented Identities: reading subjectivity in Henry Tonks' surgical portraits', *Art History*, 32, 3 (2009), 578-607; M. Park, *Art in Madness: Dr. W. A. F. Browne's collection of patient art at Crichton Royal Institution* (Dumfries, 2010); S. Gilman (ed.), *The face of madness: Hugh Diamond and the origin of psychiatric photography* (New York, 1976); G. Didi-Huberman, *Invention of Hysteria: Charcot and the photographic iconography of the Salpêtrière* (trans. A. Hartz, Cambridge, MA, 2003); T. A. Woloshyn, 'Patients rebuilt: Dr Auguste Rollier's heliotherapeutic portraits, c. 1903-1944', *Journal of Medical Humanities*, 39 (2013), 38-46; L. J. Jordanova, 'Portraits, patients and practitioners', *Journal of Medical Humanities*, 39 (2013), 2.

The representation of illness

Historians' interest in medical portraiture reflects a wider interest in the representation of illness. Indeed, John Pickstone commented in 2008 that "concerns with representations seem to have substantially replaced concerns with knowledge and power" in the history of medicine. However, the concept of representation has not been uniformly interpreted by social and cultural historians of medicine – at least when applied to illnesses.

Social historians of medicine (in particular, though not exclusively) have paid much attention to written descriptions of illness, which have often been used to evince subjective accounts of suffering (see below). In this fashion, such historians have matched historicist literary scholars. Indeed, Pickstone was responding to what he deemed to be "major inputs from literary studies" that had taken a cultural turn.[3] Diary entries, autobiographies, letters and literary evocations have all been 'representations' of illness in this sense.[4]

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[3] J. V. Pickstone, 'A brief history of medical history', history.ac.uk/makinghistory/resources/articles/history_of_medicine.html; accessed 28th January, 2013.

[4] T. Cooper, 'Richard Baxter and his Physicians', *Social History of Medicine*, 20, 1 (2007), 1-19; J. Lane, '"The doctor scolds me": The diaries and correspondence of patients in eighteenth century England', in R. Porter (ed.) *Patients and practitioners: Lay perceptions of medicine in pre-industrial society* (Cambridge, 1985), 205-48; C. Lawlor and A. Suzuki, 'The Disease of the Self: Representing Consumption, 1700-1830', *Bulletin of the History of Medicine*, 74, 3 (2000), 548-94; C. Lawlor, 'Fashionable Melancholy', in A. Ingram, S. Sim, C. Lawlor, R. Terry, J. Baker and L. Weatherall-Dickson, *Melancholy Experience in Literature of the Long Eighteenth Century: Before Depression, 1660-1800* (Basingstoke, 2011), 25-52; P. Rieder, 'Patients and Words: A Lay Medical Culture?', in G. S. Rousseau, M. Gill, D. Haycock and M. Herwig (eds.), *Framing and Imagining Disease in Cultural History* (Basingstoke, 2003), 215-30; L. W. Smith, '"An Account of an Uncontrollable Distemper": The Experience of Pain in Early Eighteenth-Century England and France', *Eighteenth Century Studies*, 41, 4 (2008), 459-480; W. Wild, 'Doctor-Patient Correspondence and in Eighteenth-Century Britain: A Change in Rhetoric and Relationship', *Studies in Eighteenth-Century Culture*, 29 (2000), 47-64; G. S. Rousseau, 'Medicine and the Muses: an approach to literature and medicine', in M. M. Roberts and R. Porter (eds.), *Literature and Medicine during the Eighteenth Century* (London and New York, 1993), 23-57; R. A. Anselment, '"The Wantt of Health": An Early Eighteenth-Century Self-Portrait of Sickness', *Literature and Medicine*, 15 (1996), 225-243; D. E. Shuttleton, *Smallpox and the Literary Imagination, 1660-1820* (Cambridge, 2007); J. Wiltshire, 'Fanny Burney's Face, Madame d'Arblay's veil', in Roberts and Porter (eds.), *Literature and Medicine*, 245-65; M. J. Healy, 'Fictions of Disease: Representations of Bodily Disorders in Early Modern Writings', Uni. of London Ph.D. thesis, 1995; M. Schoenfeld, 'Aesthetic and Anaesthetic: the Art of Pain Management in Early Modern England', in J. F. Van Dijkhuizen and K. A. E. Enenkel (eds.), *The Sense of Suffering: Constructions of Physical Pain in Early Modern Culture* (Leiden and Boston, 2008), 19-38; G. Hornstein, 'Bibliography of First-Person Narratives of Madness in English'.

Limiting the term to written sources does it scant justice. The word 'representation' triggers the connotations of (re-)presenting – i.e. of showing or making present and visible (see chap. I). Such a view has a pedigree in the social and cultural histories of medicine that stretches back at least to the 1980s. Part catalysed by debates centring on the 'visuality' of AIDS and part catalysed by the visual turn in cultural studies (now visual culture studies), historians of medicine increasingly recognised that visual material could not be treated in isolation from other forms of cultural signification, be they 'high' or 'low'.[5] Thus could Ludmilla Jordanova argue in 1990 that "through the study of medical images it is possible to touch on all aspects of health and healing".[6] Thus could Sander Gilman argue in 1995 for a "new history of medicine rooted in the study of the visual image".[7]

Recognising the visual is one thing; ascribing it interpretational value is another. As Gilman has noted, visual sources have largely been interpreted in four main ways: 1) as unmediated windows onto past medicine; 2) as illustrative evidence for arguments about past medicine; 3) to examine iconographies of health and illness; and 4) as the means to recover "cultural fantasies" of illness. As he put it: "The 'antiquarians' [1) and 2) above] use them as illustrations and representations of facts about the real world, while the 'historians' [3) and 4) above] use them as documents to show a self-contained visual language or iconography concerning health and illness that exist in specific traditions of visual representation and as objects to access cultural fantasies about health, disease and the body."[8]

The 'antiquarians' have been sharply criticised, mainly for failing to anchor the images in their due cultural and social contexts, for giving them undue documentary status,

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http://www.gailhornstein.com/files/Bibliography_of_First_Person_Narratives_of_Madness_5th_edition.pdf; accessed 15th April, 2013.

[5] R. Cooter and C. Stein, 'Coming into focus: Posters, power and visual culture in the history of medicine', *Medizinhistorisches Journal*, 42, 2 (2007), 200. On visual culture generally, see M. Dikovitskaya, *Visual Culture: the study of the visual after the cultural turn* (Cambridge, MA and London, 2006); K. Moxey, 'Nostalgia for the real: the troubled relation of art history to visual culture', in A. Bolvig and P. Lindley (eds.), *History and Images: Toward a new Iconology* (Tourhout, 2003), 45-55.

[6] L. J. Jordanova, 'Medicine and visual culture', *Social History of Medicine*, 3, 1, (1990), 90.

[7] S. Gilman, *Health and Illness: Images of Difference* (London, 1995), 163.

[8] Gilman, *Health and Illness*, 11. For examples, see *ibid.*, 14, 15, 17, 18f.

and for using them as ancillary sources.[9] Avoiding some of these pitfalls, the 'historians' have interpreted images as access points for social discourses, as means of social and cultural control (and power), as repositories of social and cultural anxieties concerning health and illness, and as producers and regulators of medical knowledge and understanding.[10]

In this thesis, I hope to suggest ways of uniting a number of these findings and a number of Gilman's representational strategies. It also bridges the concerns that Pickstone considered separate. Portraits of patients can help us scrutinise how iconographies, cultural 'fantasies', power and knowledge actually coalesced in practice – for instance in the making of clinical sketches and medical illustrations (see chaps. III and IV). This builds on important foundation work in the wider history of medicine (and science).[11] Moreover, analysed on its own terms but with reference to other genres, portraiture can help us query the (artistic, personal, social and cultural) meanings of representation. But it can also evince "facts about the real world" of past medicine without committing the "documentary fallacy".[12]

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[9] See e.g., F. Haslam, *From Hogarth to Rowlandson: Medicine in Art in Eighteenth-century Britain* (Liverpool, 1996; A. E. H. Emery and M. L. H. Emery, *Surgical and Medical Treatment in Art* (London, 2006); L. S. Dixon and G. P. Weisberg (eds.), *In Sickness and in Health: disease as metaphor in art and popular wisdom* (Newark, 2004).

[10] Jordanova, *Defining Features*; Cooter and Stein, 'Coming into focus', 180-209, esp. 183; L. Cartwright, *Screening the Body; Tracing Medicine's Visual Culture* (Minneapolis, 1995); R. van de Vall and R. Zwijnenberg (eds.), *The Body Within: Arts, Medicine and Visualization* (Leiden and Boston, 2009). S. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (Ithaca and London, 1988); *idem*, *Picturing health and illness: images of identity and difference* (Baltimore, 1995); *idem*, *Health and Illness: Images of Difference* (London, 1995); R. Porter, *Bodies Politic: Death and Doctors in Britain, 1650-1900* (London, 2001); C. Boeckl, *Images of leprosy: disease, religion and politics in European art* (Kirksville, 2011); H. E. Palfreyman, 'Visualising Venereal Disease in London, *c.* 1780-1860', Uni. of Warwick Ph.D. thesis, 2012.

[11] Cf. for instance the Society for the Social History of Medicine's 2010 conference: 'Knowledge, Ethics and Representations of Medicine and Health'. One prompting question was "What kind of material, visual and textual representations of body, mind, health and disease have gained 'defining power' exerting influence on medical practice". See http://www.dur.ac.uk/chmd/news/eventdetails/?eventno=5240; accessed 28th July, 2013.

[12] Jordanova, 'Medicine and visual culture', 91.

The point in relating these two historiographies specifically to patients and sufferers derives from historians' interest in the 'patient's view' of early-modern medicine.[13] Patient's-view histories were conceived to supply what doctor's-view histories had supposedly overlooked. But there has been little consensus about what the phrase actually means.

Two very similarly titled articles in the mid-1980s conceived the patient's view very differently. David Armstrong considered it a technique demanded by changing structures of medical practice. Inspired by Foucault, Armstrong referred to the patient's view as "an artefact of socio-medical perception".[14] For Roy Porter, however, recovering the patient's view was all about supplementing patients' experiences and beliefs by asserting their *agency*.[15] In vaguely *marxisant* terms, he advocated a patient's history "from below" that would recover what patients actually knew and did. He alleged that the patient was not a silent or passive object of medical attention – *pace* the Foucault school – but a medically knowledgeable person who could decide for himself what care he needed, and in many cases provide it as well.[16]

Historians have also debated patients' place in the (discursive and practical) systems of early-modern medicine. In 1978, Nicholas Jewson argued persuasively that the sick man "disappeared" from early-modern British medical 'cosmology' toward the end of the eighteenth century. Jewson argued that the sick-man was replaced as the main arbiter of medical knowledge about himself by his doctor.[17] Michel Foucault claimed much the same for French medicine, with the added proviso that the patient's disappearance owed more to

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[13] Though cf. D. Guthrie, 'The Patient: A Neglected Factor in the History of Medicine', in Z. Cope (ed.), *Sidelights on the History of Medicine* (London, 1957), 126-135.

[14] D. Armstrong, 'The Patient's View', *Social Science and Medicine*, 18 (1984), 737-744, at 743.

[15] R. Porter, 'The Patient's View: Doing medical history from below' *Theory and Society,* 14, 2, (1985), 175-198; *idem*, 'The patient in England, c. 1660-c. 1800', in A. Wear (ed.), *Medicine in society: historical essays* (Cambridge, 1992), 91-118.

[16] Porter, 'The Patient's View', 186. See also e.g. Porter (ed.), *Patients and practitioners*.

[17] N. D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870, *Sociology*, 10, 2 (1978), 225-44.

changing structures of medical knowledge, which reduced the patient to the epistemological status of depersonalised disease-bearing entities.[18] Mary Fissell's study of eighteenth-century Bristol's medical institutions supported these broad sociological insights: patient 'histories' – i.e. patients' subjective testimonies – were superseded by the authority of doctors' own investigations into diseases, which became the focus of the profession. Fissell's book typifies how the concepts of power and agency have been two fulcra of patient's view history.[19] Allying this patient-view historiography to those on illness representation and medical portraiture is one way of helping us scrutinise how representation, power and knowledge actually plaited.

If Armstrong, Porter, Jewson and Fissell considered the patient's view primarily in terms of doctor-patient relations (see below), other historians have been more interested in first-hand, subjective experiences of early-modern suffering. For historians like Michael Stolberg, a patient-view history is an account of *homo patiens*, of mankind in his suffering. In this sort of vein, Lucinda Beier examined seventeenth-century Britons' ailments and their responses to them – what she termed the "experience of illness".[20] Twenty years on, Lisa Wynne Smith has also traced accounts of the experience of illness, specifically pain, in early-modern England and France.[21]

Such accounts of patients' experiences have been supplemented in many ways. Howard Brody, George Rousseau, Charles Rosenberg, David Harley and Wayne Wild have examined the vocabulary and the array of metaphors used to convey contemporary understandings of eighteenth century illnesses. Fanny Burney's graphic account of her mastectomy in 1811 is one example of the material considered by such historians.[22] Fay

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[18] M. Foucault, *The Birth of the Clinic: an archaeology of medical perception* (trans. A. M. Sheridan Smith, London, 1976).

[19] M. E. Fissell, *Patients, Power and the Poor in Eighteenth-Century Bristol* (Cambridge and New York, 1991).

[20] L. M. Beier, *Sufferers and Healers: The experience of illness in Seventeenth-Century England* (London and New York, 1987).

[21] Smith, 'An Account of an Uncontrollable Distemper'.

[22] See H. Brody, *Stories of Sickness* (Oxford and New York, 2nd ed., 2003); Wiltshire, 'Fanny Burney's face'; Rousseau, 'Medicine and the Muses'; C. E. Rosenberg and J. Golden (eds.), *Framing Disease: Studies in cultural history* (New Brunswick, 1992); D. N. Harley, 'Rhetoric and the Social Construction of Sickness and Healing',

Bound Alberti and Gail Kern Paster, meanwhile, have considered the sentimental experience of being ill.[23]The 'bodily turn' has seen historians – particularly those interested in gender – examine the implications of disease and suffering on the body and on how bodies were 'managed'.[24]

Flurin Condrau has recently argued that patient's view history suffers from what we might call boundary issues. He claimed that definitions of the patient's view vary according to the "arena" in which historians formulate them. Although Condrau did not explain precisely what he meant by "arena", he is right to call attention to the fact that historians with different approaches to the history of medicine will find it hard to formulate a transferrable definition of the patient's view and to agree on where the patient's view ought to derive from.[25] It is my contention, however, that portraits of patients and sufferers will take the social history of medicine beyond the patient's view. Portraits evince the *mediation* of illness and illness-affected relationships. They do not just elicit the experience of being ill, or the social forces affecting suffering/illness (like changing medical practices), or patients' agency. The properties of portraits that I shall describe below – such as their deep engagement with individual person-hood – enable us to analyse what it meant to convey *being* a sufferer or patient in visual form. The mediating properties of portraiture offer views of the patient's view of early-modern medical life. Indeed, it is in recognising this one

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Social History of Medicine, 12, 3 (1999), 407-435; Wild, 'Doctor-Patient Correspondence'; S. Sontag, *Illness as Metaphor* (New York, 1978).

[23] F. B. Alberti, 'Bodies, Health, and Minds: Why Emotions Matter to Historians of Science and Medicine', *Isis*, 100, 4 (2009), 798-810; G. K. Paster, *The Body Embarrassed: Drama and the Disciplines of Shame in Early-Modern England* (Ithaca, 1993). See also P. M. Gouk and H. Hills (eds.), *Representing Emotions: New Connections in the Histories of Art, Music and Medicine* (Aldershot, 2005); G. K. Paster, K. Rowe and M. Floyd-Wilson (eds.), *Reading the Early-Modern Passions: Essays in the Cultural History of Emotions* (Philadelphia, 2004).

[24] W. D. Churchill, 'The Medical Practice of the Sexed Body: Women, Men and Disease in Britain, c. 1600-1740', *Social History of Medicine*, 18, 1 (2005), 3-22; B. Duden, 'Medicine and the History of the Body: The Lady of the Court', in J. Lachmund and G. Stollberg (eds.), *The Social Construction of Illness* (Stuttgart, 1992), 39-51; *eadem*, *The woman beneath the skin: a doctor's patients in eighteenth-century Germany* (Cambridge, 1991; L. J. Jordanova, *Sexual Visions: Images of gender in science and medicine between the eighteenth and twentieth centuries* (London, 1989); V. Kelly and D. von Mücke (eds.), *Body and Text in the Eighteenth Century* (Stanford, 1994); K. Park, *Secrets of Women*: *gender, generation and the birth of dissection* (New York, 2006); cf. J. Butler, *Undoing Gender* (London, 2004).

[25] F. Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine*, 20, 3 (2009), 525-40, at 536.

remove from conventional patient's view history that portraits can begin to combine themes like representation and power.

Early-modern doctors

The third lacuna that the medical portraiture historiography exposed – i.e. the place of medical portraits in doctors' practices – integrates this investigation into the enormous historiography on doctoring. Certain themes are particularly salient in the historiography of early-modern doctors. Doctor-patient relationships have been scrutinised for what they reveal about power, agency, contested knowledge and doctors' 'manner' (at the bedside or the dissecting table, for instance).[26] Professionalization has been another focus. Historians like William Bynum and Susan Lawrence have charted how training became routine and gradually institutionalised, culminating in the requirement of licences.[27] Doctors – not unlike other occupational groups – carved out specialised knowledge niches, through which they could claim a greater expertise than their patients. Publications and learned societies encouraged belief in an elite cadre of medical experts.

Given that historians have also analysed the importance of visual skills to early-modern medics, particularly anatomists, it is necessary to ask about the significance of

[26] Wiltshire, 'Fanny Burney's Face'; A. Suzuki, 'Framing psychiatric subjectivity: doctor, patient and record-keeping at Bethlem in the nineteenth century', in J. Melling and B. Forsythe (eds.), *Insanity, institutions, and society, 1800-1914: a social history of madness in comparative perspective* (London and New York, 1999), 115-35; G. B. Risse, 'Cullen as clinician: organization and strategies of an eighteenth-century medical practice', in A. Doig, J. P. S. Ferguson, I. A Milne and R. Passmore (eds.), *William Cullen and the eighteenth-century medical world* (Edinburgh, 1993), 133-51; Lane, 'The doctor scolds me'; Jewson, 'Disappearance of the Sick Man'; M. E. Fissell, 'The disappearance of the patient's narrative and the invention of hospital medicine', in R. French and A. Wear (eds.), *British Medicine in an Age of Reform* (London and New York, 1991), 92-109; A. Digby, *Making a medical living: Doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994); C. Crawford, 'Patients' Rights and the Law of Contract in Eighteenth-Century England', *Social History of Medicine*, 13, 3 (2000), 381-410. And for a more general account, see C. Helman, *Doctors and Patients: An Anthology* (Abingdon, 2003).

[27] S. C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge and New York, 1996); *eadem*, 'Educating the senses: students, teachers and medical rhetoric in eighteenth-century London', in W. F. Bynum and R. Porter (eds.), *Medicine and the five senses* (Cambridge, 1993), 154-78; W. F. Bynum, 'Physicians, Hospitals and Career Structures in eighteenth-century London', in W. F. Bynum and R. Porter (eds.), *William Hunter and the eighteenth-century Medical World* (Cambridge, 1985), 105-128.

portraits in wider medical matters. What did portraits do in doctor-patient relationships, in routine practices, in relationships of knowledge and so on (cf. chaps. III and IV)? The broad answer is that portraits of patients and sufferers encased historical anxieties, attitudes and efforts concerning medicine, and embodied fundamental ways of working in medicine. It is therefore a central argument of this thesis that portraits of patients and sufferers can help historians to analyse *doctors'* history as well as patients' history – indeed that portraits of patients and sufferers are, evidentially speaking, at least as useful in analysing doctors as doctors' own portraits.

Period boundaries

What follows is an attempt to pursue some of these historiographical leads. I have confined this pursuit to the period c. 1660-c. 1850. I say confined, this thesis nevertheless covers a very long 'long eighteenth century'. Historians of medicine are not averse to treating long periods of time, but some justification is needed for this particular periodization.[28]

1660, the Restoration, has long been the beginning of the long eighteenth century in Britain for many types of historical enquiry – including the history of medicine.[29] Although Peter Gibson's recent survey volume of the period in the *Brief History of Britain* series spanned precisely 1660-1851, it is less common to end the long eighteenth century c.

[28] E.g. S. J. M. M. Alberti, *Morbid Curiosities: Medical Museums in Nineteenth-Century Britain* (Oxford, 2011), 11; J. Lane, *A Social History of Medicine: Health, healing and disease in England, 1750-1950* (London and New York, 2001); M. Lindemann, *Medicine and Society in Early Modern Europe*(Cambridge, 1999).

[29] L. Weatherill, *Consumer Behaviour and Material Culture in Britain 1660-1760* (London and New York, 1998); P. Gauci, *Regulating the British Economy, 1660-1850* (Farnham, 2011); W. Gibson and R. G. Ingram (eds.), *Religious Identities in Britain, 1660-1832* (Aldershot, 2005); J. Hoppit (ed.), *Parliaments, nations and identities in Britain and Ireland, 1660-1850* (Manchester, 2003); J. Black, *Culture and society in Britain, 1660-1800* (Manchester, 1997); A. Clayton, *The British Officer: Leading the Army from 1660 to the Present* (Harlow, 2007. In the history of medicine, see Jordanova, *Defining Features*; Lawlor, 'Fashionable Melancholy'; Porter, 'The Patient in England'; S. J. Rigal, *Medicine in Great Britain from the Restoration to the Nineteenth Century: 1660-1800: An Annotated Bibliography,* (New York, Westport and London, 1992); Shuttleton, *Smallpox and the Literary Imagination*. See also R. Porter and D. Porter, *In Sickness and in Health: The British Experience 1650-1850* (London, 1988); R. Porter (ed.), *The Popularization of Medicine 1650-1850* (London and New York, 1992), J. R. Smith, *The Speckled Monster: smallpox in England, 1670-1970, with particular reference to Essex* (Chelmsford, 1987) and A. Wear, *Knowledge and Practice in English Medicine, 1550-1680,* (Cambridge 2000) for boundary dates within 20 years of 1660.

1850.[30] 1800 or 1832 are more often chosen. I adopt 1850 for two main reasons, the one historiographical, the other evidential.

As an historiographical 'turning point', 1850 has a reasonably long pedigree in the history of medicine. Roy Porter took several of his early-modern volumes down to 1850, for instance.[31] Jenner and Wallace took their volume on colonial medicine down to c. 1850, too.[32] Jonathan Gillis has argued that it was c. 1850 that patients' own accounts of their histories began to be treated as too superficial and to be superseded by doctors'.[33] Scholars have also noted the importance of the 1858 Medical Act in wringing significant change to the medical profession – ostensibly uniting it and paving the way for the general practitioner and full national licensing.[34] Another reason for opting to end c. 1850 is that scholars have used it as a *starting* point for enquiries into later nineteenth-century medicine.[35]

The second motivation for choosing these period boundaries is that, in artistic terms, they bracket a more-or-less manual age. The crucial matters of the nature of personal agency and personal skills altered as mechanical technologies of graphic reproduction increased in number, variety and level of automation. Basically, I have tried to avoid the age of the photograph. This specific technology/image form had an enormous and lasting impact, not only on the production of portraits, but also on 'visuality' itself (see below).[36] Moreover, doctors developed distinct habits with photography – both as a means

[30] W. Gibson, *Britain 1660-1851: The Making of the Nation* (London, 2011). Yet see some of the volumes in the above note.
[31] Porter and Porter, *In Sickness and In Health*; Porter (ed.), *Popularization*.
[32] M. S. R. Jenner and P. Wallis (eds.), *Medicine and the Market in England and Its Colonies, c. 1450-c. 1850* (Basingstoke, 2007).
[33] J. Gillis, 'The History of the Patient History since 1850', *Bulletin of the History of Medicine*, 80, 3 (2006), 490-512; cf. Suzuki, 'Framing psychiatric subjectivity', 117.
[34] C. Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain, 1850-1914', *Journal of Contemporary History*, 20, 4 (1985), 503-520, at 506.
[35] E.g. A. Hardy, 'Rickets and the Rest: Child-care, Diet and the Infectious Children's Diseases, 1850-1914', *Social History of Medicine*, 5, 3 (1992), 389-412; *eadem*, 'Cholera, quarantine and the English preventive system, 1850-1895', *Medical History*, 37, 3 (1993), 250-269; Lawrence, 'Incommunicable Knowledge'.
[36] See e.g. G. Seiberling, *Amateurs, Photography and Mid-Victorian Imagination* (Chicago, 1986), ch. 1.

of looking at patients and as a half-professionally-helpful, half-enjoyable-amateur activity.[37] Photography was very much in its infancy during the final few decades of this investigation. Even the case-study which pushes our chronology slightly beyond 1850 (see chap. IV) does not stray into the age of the medical photograph. Patient photography has its own history, although it is one that may well overlap with and be informed by this investigation.

Questions and arguments

Four key historical questions can be distilled from this historiographical introduction:

1. How were illnesses (and patients and sufferers) represented in the early-modern period and what did such representations mean for patients' and sufferers' identity?
2. How did illnesses and the representation of illness interact with wider cultural concerns?
3. What do early-modern doctors' representations of patients (or illnesses) tell us about how they worked?
4. How were early-modern medical relationships formed and what was their significance?

Portraits shall be used to examine these questions along methodological lines I shall draw below. A chapter is given to each question.

The first question requires us to pay attention to techniques and motifs that were developed to depict the signs of suffering. (The question encourages us not to distinguish at this juncture between sufferers and patients.) By looking at different diseases and types of sitter, I argue that sitters and artists developed ways to manage the outward display of

[37] E.g. J. H. Warner and J. M. Edmonson, *Dissection: Photographs of a rite of passage in American Medicine 1880-1930* (New York, 2011).

signs of ill health. Portraiture – as the genre of art most concerned with individual appearance, self-hood and identity – prompted decisions regarding what to show and how to show it. By examining the perception of these techniques and motifs, I argue that long-eighteenth-century society was 'visually intelligent' enough to recognise these motifs and devices.[38]

The second question builds on the insights of 'showing' and 'looking' (see chap. I). It further considers how people – from many different stations in society and with different interests to serve – looked at the ill. It also considers what inferences they drew from what they saw. Character norms were particularly susceptible to visual recognition; it was perfectly legitimate to judge character by appearance. These norms therefore provide solid ground to test the effect of illness on visual perception. Indeed, I shall consider the effect of portraiture on how contemporaries linked health and character. I argue that portraits were a means to try to alter the impressions and assumptions that could be derived from certain 'ill looks'. Portraits acted as convenient 'fronts'; they helped to associate or dissociate sitters from illnesses that were (respectively) beneficial or harmful to how their characters were perceived.

Having considered some of the broad representational and interpretative concerns of depicting long eighteenth-century patients, the third question considers how these concerns manifested themselves in overtly clinical settings. I consider how doctors used portraiture clinically. As those who routinely represented the illnesses of their patients, doctors allow us to test the representative functions of patient portraits. Were patient portraits merely indices of illness, or were they individual likenesses, or were they both? Querying how such portraits came into being also leads us towards an analysis of 1) the role of portraiture within ordinary, quotidian medical practices and 2) how portraits can evince specific medical relationships between patient and practitioner(s). Ultimately, I argue

[38] On visual intelligence, see D. H. James, 'The many faces of justice: Portraiture at the Inns of court from the Restoration to 1850', Uni. of London M.A. essay, 2010, 2; L. J. Jordanova, *The Look of the Past: Visual and Material Culture in Historical Practice* (Cambridge, 2012), esp. ch. 2.

that portraits were fundamental to normal working practices – at least as fundamental as text. I also argue that doctors used them for a wide variety of purposes, not the least of which could be to *combine* general illness categorisation and individual patient care. Further, I claim that portraits reveal subtler medical relationships than historians have hitherto been aware of. These points contribute to the claim that patient portraits are just as useful in studying doctors as doctors' own portraits.

The fourth question expands the investigation of medical relationships. Building on broad scholarship that suggests that portraits can generate as well as evince relationships, I query the role of portraits within different kinds of early-modern medical relationship. I analyse portraits' relationship-defining properties at various occupational, social and cultural levels. I examine what properties portraits were invested with – such as the ability to convey medical knowledge as a special kind of illustration. Ultimately, I show how portraits could even invoke what exactly was medical about certain relationships. This ability relied on conscious collective efforts to use portraiture to bind people together in specific ways. Portraiture was therefore not just a way to document early-modern relationships, but a way to form them and 'live' them.

Contexts

Some historical background is needed to set up these investigations. If we are to assess the impact of illness on identity, we need to know what 'illness' actually was in this period. And we shall want to know how portraits were thought to convey character and identity, indeed why portraits were valued above other image genres. If we are to assess how someone looked on another person and what they inferred, we shall want to know about contemporary vision and common visual skills. To answer anything about how doctors worked or about medical relationships, we shall need to know about the structures and

practices of medicine, and what sufferers could do when they were ill. We shall also need to know whom contemporaries thought of as patients.

Illness and its responses

Medicine was a central concern of early-modern British society for two main reasons. First, just like enlightened impulses of sensibility, refinement and politeness, medicine sought to improve the general human condition. Second, just as for much of British history, illness was an everyday matter. Very few people were exempt from it. But what were the common understandings of illness and being ill in our period?

The concept of illness was inextricably linked to the general understanding of the body. Theories of a fluid, porous, humoural body, of vital spirits and of individual constitutions coexisted with Newtonian 'iatromathematical', mechanistic and 'nervous' conceptions of the body.[39] Accordingly, to be ill was to suffer from a deficiency or excess of one of the four humours (melancholy, yellow bile, phlegm and blood). Or it was to suffer from the 'stagnation' of bodily fluids.[40] Or it was to suffer from excited nerves or from a mechanical breakdown of a body part. Indeed, even if a holistic view of the body generally prevailed, it was recognised that certain ailments targeted certain parts of the body; books and treatises on specific organs proliferated, as did the concoction of organ-specific remedies. Disabilities and bodily impairments – being functional breakdowns – were considered pathological. So were certain forms of mental instability, like mania. The notion that diseases were specific invasive entities really only began to appear toward the end of our period, although practices like inoculation and vaccination propelled arguments in favour of it.

[39] See Lindemann, *Medicine and Society*; M. E. Fissell, 'Readers, Texts and contexts: Vernacular medical works in early modern England', in Porter (ed.), *Popularization*, 72-96; Wear, *Knowledge and Practice*, esp. 39 for a useful summary of the humoural 'system'.
[40] Wear, *Knowledge and Practice*, 38.

It was common to think that there were correlations between things inside and outside the body – i.e. between bodily health and the environment or conditions of life. Air could be foul and miasmic. One could still overheat in hot climes and catch chills when it was chilly. 'Non-naturals' including sleep remained crucial to general well-being. Indeed, observing a bodily regimen to keep one's constitution stable was considered the best means of preventing illness. This view persisted well into the nineteenth century.[41] Gradually, as public health increased in the social consciousness, the notion arose that the work one did – and where one did it – also affected health and the propensity to suffer different complaints.[42] Notwithstanding all this, many still thought that God was the final arbiter of disease (and death).[43] From someone like Alexander Pope at the beginning to someone like William Gladstone at the end of our period, people from all walks of life continually attributed the flux of good and bad health to God.[44]

As for getting rid of unwanted ailments, if prayer did not avail you, then evacuation was deemed the most effective expeller. Purging or sweating helped to get the body 'moving' again and restore equilibrium. Botanical and herbal 'specifics' aimed to treat all manner of localised complaints. Panaceas and universal nostrums were widely peddled, too, even though contemporaries reasoned that different people needed different cures for different health problems.[45]

In sum, most people in long eighteenth-century British society had a rudimentary (though not necessarily common) understanding of how the body worked and what it meant for the body to go wrong.

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[41] Lindemann, *Medicine and Society*, 10ff.

[42] On occupational health, see C. Thackrah, *The Effects of the Principal Arts, Trades, and Professions...on Health and Longevity* (Leeds, 1832).

[43] Pope to Warburton, n.d., in *The Correspondence of Alexander Pope* (ed. G. Sherburn, 5 vols.., Oxford, 1965), iv, 505; Pope to Caryll, 28th October, 1720, *Correspondence of Alexander Pope*, ii, 57.

[44] E.g. R. Jenkins, *Gladstone* (London and Basingstoke, 1996), 180.

[45] On "children's physic", for instance, see H. C. Newton, 'The Sick Child in Early Modern England, c. 1580-1720', Uni. of Exeter Ph.D. thesis, 2009, 9ff, 77ff and *passim*.

With such knowledge, self-help was possible. And it was encouraged. The adage that prevention was better than cure well befits the medical sensibility of early-modern Britain.[46] Vast amounts of physical and mental energy went into keeping oneself healthy. Regimens were recorded in commonplace books.[47] Self-help manuals – which praised moderation of diet, warned against over-excitement, and encouraged medical optimism – appeared throughout the century. These increased medical knowledge and by turn the chance of self-help.[48] Some, like John Wesley's *Primitive Physick* (1747) or John Buchan's *Domestic Medicine* (1785) sat next to the Bible on the common man's bed-table and went through several editions. John Gunn's *Domestic Medicine* (1830) was specifically conceived as a *Poor man's friend*. Such volumes shared space on the bookshelf with recipe books and herbals. Culpeper's *Herbal* (1653) was a classic.[49] There was a prolific traffic in sharing recipes, both orally and in manuscript form. Like learning through manuals, recipe swapping increased general medical awareness.[50]

Other publications also diffused medical advice and expertise. The *Gentleman's Magazine* disseminated medical knowledge to interested laymen.[51] Almanacs often included copious medical advice, too.[52] Moreover, books on openly medical themes could be targeted at a lay readership. Robert Kinglake's *Dissertation on gout* (1804) was dedicated to the 3rd duke of Portland, a notorious sufferer of gout. It included a medical glossary "to prevent any obscurity which may arise to the genteel or unprofessional reader".[53]

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[46] See e.g. E. Leong and S. Pennell, 'Recipe Collections and the Currency of Medical Knowledge in the Early Modern "Medical Marketplace"', in Jenner and Wallis (eds.), *Medicine and the Market*, 133-52, at 134ff.

[47] A. Goldblom, 'Lay Medical Culture and its English Critics, c. 1620 to c. 1720', Uni. of London Ph.D. thesis, 2000.

[48] See the essays in Porter (ed.), *Popularisation*; and also G. Smith, 'Prescribing the rules of health: Self-help and advice in the late eighteenth century', in Porter (ed.), *Patients and practitioners*, 249-82; cf. Porter and Porter, *In Sickness and In Health*.

[49] Porter (ed.), *Popularization*, 2.

[50] Leong and Pennell, 'Recipe Collections', 141ff, esp. 144, 146.

[51] R. Porter, 'Laymen, doctors and medical knowledge in the eighteenth century: the evidence of the *Gentlemen's Magazine*', in *idem* (ed.), *Patients and practitioners*, 283-314, esp. 293-5.

[52] L. H. Curth, 'Medical Advertising and the Popular Press: Almanacs and the Growth of Proprietary Medicine', in *eadem* (ed.), *From physick to pharmacology: Five hundred years of drug retailing* (Aldershot, 2006), 29-47, at 24ff.

[53] R. Kinglake, *A dissertation on gout* (London, 1804), ix.

Moreover, the *Lancet* was originally conceived as a *Literary Medical Journal* that was not intended only for the medical faculty. Public lectures also gave ever-widening access to detailed and up-to-the-minute medical knowledge.[54]

Given the extent of the spread of medical knowledge and the preference for self-help, the services of a medical practitioner were more often than not a last resort.[55] That is even truer when we take into account the extensive role(s) of relatives in health care (see below). Medics were nonetheless called on regularly – a point which suggests by itself just how common it was to be ill. Patients often availed themselves of the services of many practitioners, not just one or two. The Marquess of Rockingham called on at least seven different doctors at different stages in his life; and the duke of Richmond once said that Rockingham died of a "surfeit of physick".[56] Moreover, one could call on different types of practitioner. Within a single year, Samuel Pepys used James Boyle, a Harley Street doctor, as well as a lowly recipe-peddling woman.[57]

Practitioners

There were three main formally-trained medical practitioner groups in early-modern Britain: physicians, surgeons and apothecaries. They jostled for market position and for their expertise to be recognised.[58] Physicians studied for MDs at university. Although physicians like Thomas Sydenham promoted empirical bed-side observation above book-learning, the university training institutionalised the academic nature of physic.[59] Physicians sought upper-market clienteles to whom they could deliver bookish diagnoses and

[54] Lane, *Social History of Medicine*, 27.
[55] Lindemann, *Medicine and Society*, 224.
[56] M. Bloy, 'In spite of medical help: The puzzle of an eighteenth-century prime minister's illness', *Medical History*, 34 (1990), 178-84.
[57] S. Pepys, *The Diary of Samuel Pepys* (ed. R. Latham and W. Matthews, London, 11 vols.., 1970-83), ix, 248, 537.
[58] There are useful discussions in D. Gentilcore, *Medical Charlatanism in Early Modern Italy,* (Oxford, 2006), ch. 1 and in Lane, *A Social History of Medicine,* 1ff.
[59] On Sydenham, see e.g. Wear, *Knowledge and Practice*, 448ff.

treatments by correspondence, or by home visit.[60] Renowned physicians like Sir John Radcliffe, Sir Hans Sloane and Richard Mead could charge such well-heeled clients a guinea per letter; and they amassed princely wealth.

Physicians commonly styled themselves – as did many of their clients – as learned gentlemen of the mind and the pen. Indeed, many physicians were celebrated authors: among them, John Arbuthnot, Oliver Goldsmith and George Crabbe. To such men, their classical libraries were as important as their clinical work. They spent much of their medicine-made money on classically-inspired cultural pursuits (see chap. IV). Early-modern physicians were bastions of a culture of gentlemanliness. This was girded by general erudition, not specifically medical learning. William MacMichael, in his celebrated *Gold-headed Cane* (1828), reported Radcliffe to have said that "every year of my life has convinced me more and more of the value of the education of the scholar and the gentleman, to the thorough-bred physician."[61]

The predominance of this general cultivation persisted among doctors right up to the end of our period. When Charles Lucan wrote to William Oliver that "Honor [*sic*] and Humanity are as necessary qualifications for a physician, as knowledge in medicine", he invoked the same gentlemanly ethic as William Munk did over a century later when writing that Henry Herbert Southey garnered success because "he was remarkably handsome, active, athletic and fond of sports in the field" and so "became a great favourite...of many of the great aristocratic families".[62]

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[60] Lane, 'The doctor scolds me'; Wild, 'Doctor-Patient Correspondence'; R. French and A. Wear, 'Introduction', in *iidem* (eds.), *British Medicine in an Age of Reform* (London and New York, 1991), 3. The title of 'Dr' should be treated with some caution. Some men – such as Robert Bragge – were styled 'Dr' despite not having an MD qualification: R. Porter, *Disease, Medicine and Society in England, 1550-1860,* (Basingstoke, 1987), 92-5.

[61] W. MacMichael, *The Gold-headed cane* (London, 1828), 37.

[62] Cit. D. N. Harley, 'Honour and Property: The Structure of Professional Disputes in Eighteenth-Century English Medicine' in A. Cunningham and R. French, (eds.), *The Medical Enlightenment of the Eighteenth Century,* (Cambridge, 1990), 138-164, at 151; W. Munk, *Lives of the Fellows of the Royal College of Physicians of England* (London, 12 vols.. 1861-2011), iii, 274. Cf. M. S. Micale, *The Mind of Modernism* (Stanford, 2004), 4.

One turned to a surgeon for the more gruesome tasks of bleeding, dentistry and what we would recognise as basic surgery, like setting bones or lancing boils.[63] Crudely formulated – although contemporaries so formulated it –, surgeons exercised their hands with knives, not their minds with books.[64] Even a cultural sophisticate like William Cheselden made his (medical) name and his money by cutting for the stone.[65] Surgeons gained their knowledge by apprenticeship – rather than academic learning – and by dissection.[66] Parliament recognised this second mode of learning in 1752 when it legalised the dissection of felons' bodies and again in 1832 when it permitted surgeons to dissect unclaimed cadavers.[67] Paying for private anatomy lectures and to 'walk' a hospital ward with a retained surgeon emerged as two auxiliary ways of gaining a medical education, particularly toward the end of our period.[68]

Over the period as a whole, surgeons fought hard for their reputation as blunt knife-wielding man-handlers to be shaken off and replaced with one that recognised their dexterity, cleverness and bodily knowledge.[69] Having split off from the Company of Barber-Surgeons in 1745, the Company – later the Royal College – of Surgeons spearheaded this campaign. As mentioned earlier, portraiture played a crucial part in it.[70]

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[63] Porter, *Disease, Medicine and Society*, 16,

[64] Porter, *Disease, Medicine and Society*, 19; B. M. Stafford, *Body Criticism: Imaging the Unseen in Enlightenment Art and Criticism* (Cambridge and London, 1991), 49.

[65] This does scant justice to the complex professional trajectories of surgeons and physicians in the eighteenth century: but the distinction was understood and helps give a basic indication of their differences.

[66] Lindemann, *Medicine and Society*, 109; Lane, J. Lane, 'The Role of Apprenticeship in Eighteenth-Century Medical Learning in England', in Bynum and Porter (eds.), *William Hunter*, 57-104; Lawrence, *Charitable Knowledge*, ch. 4.

[67] R. Porter, 'William Hunter: A Surgeon and a Gentleman', in Bynum and Porter (eds.) *William Hunter,* 7-34, at 23; R. Richardson, *Death, Dissection and the Destitute* (London, 2nd ed., 2001).

[68] S. C. Lawrence, 'Private enterprise and public interests: medical education and the Apothecaries' Act, 1780-1825', in French and Wear (eds.), *Medicine in an Age of Reform*, 45-73, at 48; *eadem*, 'Entrepreneurs and Private Enterprise: The Development of Private Medical Lecturing in London, 1775-1820', *Bulletin of the History of Medicine*, 62, 1 (1988), 171-92.

[69] L. J. Jordanova, 'Medical men 1780-1820', in J. Woodall (ed.), *Portraiture: Facing the Subject* (Manchester, 1997), 101-15; Stafford, *Body Criticism*, 49.

[70] Jordanova, 'Medical men'; Sarafianos, 'Natural History of Man'; Piper, 'Take the face of a physician'; D. N. Harley, 'Political post-mortems and Morbid Anatomy in Seventeenth-Century England', *Social History of Medicine*, 7, 1 (1994), 1-28, at 21-2. See also chap. II below.

Their efforts were by and large successful: the repute and social standing of surgeons – save perhaps military, particularly naval, surgeons – increased dramatically.

Apothecaries or druggists dispensed remedies. They also sought, and after 1704 were allowed, to give more general medical advice, provided they did not specifically charge for it.[71] They were either small shopkeepers or itinerant peddlers. Like surgeons, they trained by apprenticeships.[72]

The three thousand or so names listed in the first *Medical Register* of 1779 give a sense of the above-board choices before the patient, and a sense of the different institutions and practices that had been developed to meet the medical needs of the country.[73] Over time, surgeon-apothecaries, dispensing druggists and general practitioners emerged to complement or rival these three professions.[74] And besides the above-board, recognised (chartered or liveried) occupations, there were innumerable small-time practitioners, like Pepys' peddler. These were entrepreneurial folk who sought a small share of the "opportunity economy" of early-modern medicine. There was always room for them in the 'medical marketplace' – provided they were seen to cure.[75]

Patients and practitioners

Given the extent of lay medical knowledge, it is no exaggeration to say that sufferers could and did know as much about medicine as their doctors. Patients were not awed by what their doctors knew. Possible flattery aside, a letter from Alexander Pope to his friend Lord

[71] Lindemann, *Medicine and Society*, 165ff; Porter, *Disease, Medicine and Society*, 33.
[72] Lane, 'The Role of Apprenticeship'.
[73] P. Youngquist, *Monstrosities: Bodies and British Romanticism* (Minneapolis and London, 2003), xxiv.
[74] Palfreyman, 'Visualising Venereal Disease', 9.
[75] R. Porter, *Health for sale; quackery in England, 1660-1850* (Manchester, 1989); K. P. Siena, 'The "Foul Disease" and Privacy: The Effects of Venereal Disease and Patient Demand on the Medical Marketplace in Early Modern London', *Bulletin of the History of Medicine*, 75, 2, (2001), 199-224; Gentilcore, *Medical Charlatanism*.

Bathurst suggests how a patient might know at least enough to engage critically with doctors' practices:

> Many and Various Studies...possess your Lordships mind...chiefly &principally Natural Philosophy and the Art of Medicine: Witness those Instructions, which Physicians, instead of giving, receive from You, even while you are their Patient: They come to feel your pulse, & prescribe you Physick! Presumptuous Men! They return with their own pulses examin'd, & their own Bodies purg'd, vomited, or blooded....[76]

With such knowledge (in any degree), patients were more than willing to challenge their doctors' opinions, or simply to abandon them altogether if they disagreed. It must be remembered, as Jewson argued forcefully, that well-to-do patients were the patrons of their doctors. Doctors accordingly had to tailor their practices to the knowledge and whims of their client-patients.[77]

It was on the basis of the patient's knowledge and standing – as patron – that the 'history' was the primary means of diagnosing an illness at the beginning of our period. The history was generally a written or spoken account by the patient of what was ailing him. A doctor would advise on its testimony. Visual inspection – of the body or its waste – slowly gained ground as our period progressed.[78] So that George III's physicians would diagnose primarily on the basis of the king's water and stool. The testimony of visual signs gradually encroached on the implicit authority of the patient's own history.[79] This tied in with doctors' efforts to be considered the only ones skilful enough to interpret illness.

The contested nature of diagnosis prompts us to ask just how contemporaries conceptualised being a patient. It seems that patient-hood had two components. The first

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[76] Pope to Bathurst, 9th April, 1730, *Correspondence of Alexander Pope*, iii, 130.
[77] Cf. Fissell, 'The disappearance of the patient's narrative', 93.
[78] R. Porter, 'The rise of the physical examination', in Bynum and Porter (eds.), *Medicine and the five senses*, 179-97.
[79] Fissell, 'The disappearance of the patient's narrative'.

was *suffering*; the word 'patient' derived from the Latin *patior*, meaning 'I suffer'. The second component was another person's intervention or involvement in one's medical life (including death). The term 'patient' was seldom used by ill people describing, or treating, themselves. For all her illnesses and complaints, Elizabeth Freke did not think of herself as a patient, though she treated herself prolifically.[80] Yet Lady Montagu did, who sardonically scorned her copious medicaments and her fussy doctors. Patients were not self-sufficient. One was the patient of someone else. The terms 'sufferer' and 'sick' person referred to medical states of being or experiences, whereas 'patient' implied a relationship. It was a social category.

If 'patient' implied someone else's involvement, contemporaries did not specify what that involvement had to be. It was not practice-specific. There was not a fixed group of actions that transformed interpersonal dealings about health and disease into dealings between a patient and practitioner. A complex surgical operation implied a patient, but then so did the relatively simple act of wrapping someone up to keep him warm.[81] Letters from Mr Pulleyn to Sir Hans Sloane written to get Sloane's advice differ conceptually from letters between friends who regaled their ailments. Yet the category 'patient' attached to the friends just as much as to Pulleyn (cf. chap. IV).[82]

The category did not apply to specific types of people, either. Rather, it was applied to the nature of the relationship. In this sense, it was all-encompassing. A patient did not become a patient just for entering into a certain relationship on a certain implied standing with a certain person. Relatives could be physicians and patients. Josiah Wedgwood became the physician of his wife in the absence of her usual doctor: "Doc^{r} [Erasmus] Darwin has left me to act as Physician in his absence, but I believe I shall not gain much credit in my office amongst the female nurses here, as I have prescribed what they durst not think of

[80] Anselment, 'The Wantt of Health'.
[81] See WL 51428.
[82] Smith, 'An Account of an Uncontrollable Distemper'; Wycherley to Pope, 19th February, 1708/9, *Correspondence of Alexander Pope,* i, 54-5.

for my patient".[83] Similarly, in a letter to the 3rd duke of Portland (the gout sufferer) Lady Torrington hoped that Dorothy, the duke's wife, had proved "a good nurse".[84] Families regularly invoked the categories of patient-hood.

Patients varied according to wider socio-economic criteria, too. Law provided that only men could employ the services of a doctor; yet women, minors, servants and apprentices were all conceived of as patients even though they were legally under another's charge.[85] Another example would be those under the aegis of the state. Although an army officer wielded more power vis-à-vis a military surgeon than a poor person of the parish did vis-à-vis a charitable provincial practitioner, the officer and the poor man were both patients.[86] There was great variety in the nature of the relationships that bespoke of patient-hood. The term 'patient' must understand this sort of empirical variety.

Art in the long eighteenth century

As well as of patients, each of our historical questions demands an appreciation of British art in the long eighteenth century. Simply put, art boomed in this period. In a commercialising society, artworks became objects of consumption *par excellence*. Iain Pears has shown how the number of auctions, public sales and dealers all rocketed.[87] Print-shops allowed the buying public to scan and select images to suit their own preferences; right

[83] Wedgwood to Bentley, 10th September, 1772, J. Wedgwood, *The Selected Letters of Josiah Wedgwood* (ed. A. Finer and G. Savage, London, 1965).
[84] www.nottingham.ac.uk/iss/services/mss/archive-mss-catalogues/cats/port_3rdduke3cat.html; accessed 1st June, 2012.
[85] Crawford, 'Patients' Rights', 382.
[86] On naval patients, see e.g. P. K. Crimmin, 'The Sick and Hurt Board and the health of seamen, c. 1700-1806', *Journal of Maritime History* (December, 1999), www.jmh.nmm.ac.uk/[title]:Wor; accessed 16th February 2011.
[87] C. M. Sicca, *John Talman: An Early Eighteenth-Century Connoisseur* (New Haven and London, 2008), 7; I. Pears, *The Discovery of Painting: The Growth of Interest in the Arts in England 1680-1768* (New Haven and London, 1988), 53-4, 77ff, 87ff, 101f.

through our period, their enticing shop-windows were a focus for the anxiety about unfettered commerce among the leisured and tempted genteel classes.[88]

The expanding commercial art market led to the greater domestic accumulation of pictures. Carol Gibson-Wood has shown that almost two thirds of households in Restoration London owned pictures.[89] Whether bought or personally painted, art adorned the walls of more people's homes than ever before. Engraved prints were often made with interior design in mind.[90] Prints fuelled the fashion for extra-illustration – basically the practice of cutting up a book, pasting in portraits of the book's subjects and then reassembling the leaves into a now-illustrated book. Some works were made especially for extra-illustration: 'Pennant kits' appeared for Thomas Pennant's *Account of London* (1790).[91] Engravings also fostered interest in antiquities.[92] In other words, art became a vehicle for the popularity of wider cultural interests and pastimes.

Specific institutions and practices also indicate the growth of art and artistic appreciation. Godfrey Kneller's Queen Street Academy was instituted to exploit growing hunger for artistic appreciation.[93] The foundation of the Royal Academy in 1768 followed great clamouring for a 'British school' to rival the continent. Rightly could William Hunter, first professor of anatomy in the Academy, then profess that "a general taste for the Arts prevails".[94]

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[88] A. Bermingham, *Learning to Draw: Studies in the Cultural History of a Polite and Useful Art* (New Haven and London, 2000), 127; A. N. Richter, 'Spectacle, Exhibition and Display in the Gentleman's House: The Fonthill Auction of 1822', *Eighteenth Century Studies*, 41, 4 (2008), 543-63, at 544ff.

[89] C. Gibson-Wood, 'Picture Consumption in London at the end of the seventeenth century', *Art Bulletin*, 84, 3 (2001), 491-500, at 492.

[90] Bermingham, *Learning to Draw*, 150ff.

[91] L. Peltz, 'Facing the text: The amateur and commercial histories of extra-illustration', in R. Myers, M. Harris and G. Mandelbote (eds.), *Owners, Annotators and the Signs of Reading* (London and New Castle, 2005), 91-135, at 112-9.

[92] R. Sweet, 'Antiquaries and Antiquities in Eighteenth-Century England', *Eighteenth Century Studies*, 34, 2 (2001), 181-206, at 194.

[93] C. Gibson-Wood, *Jonathan Richardson: Art Theorist of the English Enlightenment* (New Haven and London, 2000), 19.

[94] M. Kemp (ed.), *Dr William Hunter at the Royal Academy of Arts* (Glasgow, 1975), 75.

Criticism flourished as general appreciation of the arts rose.[95] Arbiters of taste and style approved or disapproved of art. Connoisseurship became synonymous with close looking and pedantic description – but it relied on a more general awareness of formal properties, techniques and the ability to look at art. This awareness was fostered by art primers, among other publications. Some, like Charles Taylor's *Artist's Repository* (first ed. 1794), sought to provide a "complete system of picturesque knowledge", which included lectures on materials, design, the human figure, proportion, character and expression.[96] Society could also draw on magazines, exhibition catalogues, sale catalogues and country-house guidebooks to sharpen its critical acumen. Catalogues could be browsed in coffeehouses.[97] In March 1751, the portraitist Joseph Highmore wrote about portraiture in the *Gentleman's Magazine*.

Portraiture

As Highmore's piece suggests, art in the long eighteenth century was not monolithic, but rather divided into genres. Theory dictated that history paintings excelled portraiture in the 'hierarchy' of genres. But despite attempts to assert and reassert the prestige of history painting, portraiture came to prevail as the commonest and most discussed genre.[98] Portraiture's popularity rested on its variety, its practical/functional flexibility and the fact that it could, like history painting, evoke ideas.

Functionally speaking, portraits were made for all manner of reasons. One of the earliest uses of portraits was as signs above shops and inns. They also acted as tokens of lineage – especially when displayed in a country house drawing room. They could be a

[95] M. Hallett, "'The Business of Criticism": The Press and the Royal Academy Exhibition in Eighteenth-Century London', in D. H. Solkin (ed.), *Art on the Line: Royal Academy Exhibition at Somerset House, 1780-1836* (New Haven and London, 2001), 65-75.
[96] C. Taylor, *Artist's Repository*: *or Encyclopaedia of the Fine Arts* (London, 1815), Advertisement.
[97] Sicca, *John Talman*, 7.
[98] S. West, *Portraiture* (Oxford, 2004), 76.

reasonably cheap declaration of a sitter's worldly success or distinguished ancestry.[99] Portraits were also materially valuable objects of wider cultural significance. They commemorated heroes, for instance in the monumental sculpture of Westminster Abbey. They asserted comradeship, as among the members of the Kit-cat Club (see Figure 3). They celebrated leadership, as in the series of portraits of presidents of the Royal College of Physicians.[100] They promoted aesthetic trends, including interior decoration and the wearing of jewellery.[101] They exemplified moral values.[102] They had a strong gift-worth. Moreover, as the century progressed, portraits provided the base-images that satirists and caricaturists would warp; this 'emergent' function gave them a political potency, too.[103] All these functions relied on artists' – and portraiture's – presumed ability to display a sitter's time-less character (see chap. II).[104] Portraits transcribed person-hood and made it visible for posterity.

Portraits were bought, sold, shared, copied, cut and pasted, donated, hung, re-hung, looked at and criticised on an ever-increasing scale.[105] Portraits occupied all sorts of settings, from homes and hospitals to clubs and churches; and they dominated most public and private exhibitions.[106] They were produced in all sorts of forms, too: the commissioned

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[99] See, e.g., K. Retford, *The Art of Domestic Life: Family Portraiture in Eighteenth-Century England* (New Haven and London, 2006).

[100] These examples are embodied in, *inter alia*, Poet's Corner in Westminster Abbey, in room 9 of the National Portrait Gallery and in the central galleries of the Royal College of Physicians of London.

[101] A. J. Vickery, *Behind Closed Doors: At Home with the Georgians* (New Haven, 2009); M. Baker, 'Public Images for Private Spaces? The Place of Sculpture in the Georgian Domestic Interior', *Journal of Design History*, 20, 4 (2007), 309-23; M. Pointon, *Brilliant Effects: a cultural history of gem stones and jewellery* (New Haven and London, 2009).

[102] See esp., J. Barrell, *The political theory of painting from Reynolds to Hazlitt : the body of the public* (New Haven and London, 1986); *idem* (ed.), *Painting and the Politics of Culture: New Essays on British Art 1700-1850* (Oxford and New York, 1992); D. H. Solkin, *Painting for Money: The visual arts and the public sphere in eighteenth-century England* (New Haven, 1993).

[103] S. West, 'Wilkes' Squint: Synecdochic Physiognomy and Political Identity in Eighteenth-Century Print Culture', *Eighteenth Century Studies*, 33, 1 (1999), 65-84; Haslam, *Hogarth to Rowlandson*.

[104] Cf. J. Richardson, *A Theory of Painting* (London, 1715), 25 and D. Wilkie, 'Portrait-Painting', in P. Cunningham, *The Life of Sir David Wilkie...* (London, 3 vols.., 1843), iii, 167-8.

[105] See Pears, *The Discovery of Painting*; Weatherill, *Consumer Behaviour and Material Culture*; J. Brewer, 'Cultural Production, Consumption, and the Place of the Artist in Eighteenth-Century England', in B. Allen (ed.), *Towards a Modern Art World* (New Haven and London, 1995), 7-25.

[106] M. Pointon, 'Portrait Painting as a Business Enterprise in London in the 1780s', *Art History*, 7, 2 (1984), 187-205, at 189.

oil, the print of the engraving, the reproduction copy, the marble bust, the coin, the medal, and so on.[107] All of these betokened different values and emulated different traditions. All had their own tropes and target-audiences. Busts, for instance, became especially popular among the well-to-do. Since they were wealthy enough to purchase an expensive lump of stone and pay someone to fashion it, and since they desired to emulate their Greek and Roman forebears who were themselves enshrined in marble, aristocrats, according to Campbell's *London Tradesman* (1747), developed a "taste for Busts and Figures...rather than [for sitting] for their Pictures".[108] Medals, meanwhile, appealed to virtuosic collectors and those with antiquarian tastes. As mentioned above, engraved portraits stoked the fashions for extra-illustration and interior decoration, and were accessible further down the social pecking-order.[109]

This great variety in form and function gave rise to specific commercial production practices. By the beginning of the eighteenth century, mezzotinting had transformed from a quixotic pursuit to a commercial enterprise.[110] Stipple engravings fed the appetite for inexpensive prints in the late eighteenth and early nineteenth centuries.[111] Some artists like Arthur Pond and Gerard Vandergucht were in effect one-man businesses and made their money by being jacks of several artistic trades.[112] The livelihoods of painters, engravers and printers were buoyed on the rising tide of portraiture.[113] Portrait sittings were also organised with enterprise in mind. As Louise Lippincott has explained, portraits were

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[107] On medals, for instance, see L. Brown, *British Historical Medals: 1760-1960* (London, 3 vols.., 1980-95).
[108] Cit. M. Baker, "'No Cap or Wig but a thin Hair upon it": Hair and the Male Portrait Bust in England around 1750', *Eighteenth-Century Studies*, 38, 1 (2004), 63-77, at 64.
[109] Peltz, 'Facing the text', 100.
[110] B. Thomas, 'Noble or Commercial? The Early History of the Mezzotint in Britain', in M. Hunter (ed.), *Printed Images in Early Modern Britain: Essays in Interpretation* (Farnham and Burlington, 2010), 279-296, at 284, 293.
[111] Cit. Peltz, 'Facing the text', 126.
[112] L. Lipincott, *Selling Art in Georgian London: The Rise of Arthur Pond* (New Haven and London, 1983); S. Benson, 'Left out of the Story? Engravers in the cultural networks of the early eighteenth century', Uni. of London M.A. thesis, 2010.
[113] Cf. Lipincott, *Selling Art In Georgian London,* 161-2; *eadem*, 'Expanding on Portraiture'. Cf. V. Coltman, *Fabricating the Antique: Neoclassicism in Britain 1760-1800* (Chicago, 2006)and Solkin, *Painting for Money*.

relatively cheap and efficient to produce: props could be reused; prices fixed.[114] Often, the sitter would sit just once or twice to the master artist, who would paint the sitter's head and leave his studio to fill in the rest. Godfrey Kneller and Peter Lely were two who adopted this method, though a client could always pay more to have the master paint the whole canvas.[115]

Given all this, it is no exaggeration to say that the long eighteenth century was awash with portraits. Truly it was, as William Combe declared in 1777, "a *Portrait-Painting* Age!".[116]

Sight, perception, vision and visuality in the long eighteenth century

Portraits were painted to be seen, scrutinised and appreciated. Besides a philosophical interest in optics and the nature of sight,[117] British society developed and valued its visual intelligence. John Locke's claim that sight was "the most comprehensive of the senses" would have met with broad agreement.[118] But more than this, British society had an acute awareness of what it meant to be able to see *certain* things, and of what it was *possible* to perceive.[119] We might call this an interest in visuality.

Training the eyes was as important as learning to write. As Ann Bermingham has argued, drawing was a "basic communicative skill like writing" and was fostered as a matter

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[114] L. Lipincott, 'Expanding on Portraiture: The market, the public, and the hierarchy of genres in Eighteenth-Century Britain', in J. Brewer and A. Bermingham (eds.), *The Consumption of Culture 1600-1800: Image, Object, Text* (New York, 1995), 75-88, at 80-1.

[115] West, *Portraiture*, 11; D. Piper, *Catalogue of Seventeenth-Century Portraits in the National Portrait Gallery 1625-1714* (London, 1963), xx, xxi.

[116] W. Combe, 'A Poetic Epistle to Sir Joshua Reynolds' (1777), cit. P. de Bolla, *The Education of the Eye: Painting, Landscapes and Architecture in eighteenth-century Britain* (Stanford, 2003), 24.

[117] S. Kusukawa, 'Picturing Knowledge in the early Royal Society: the examples of Richard Waller and Henry Hunt', *Notes and Records of the Royal Society*, http://rsnr.royalsocietypublishing.org/content/early/2011/05/10/rsnr.2010.0094.full.pdf+html, accessed 2nd July 2012, 10; M. Baxandall, *Patterns of Intention: On the Historical Explanation of Pictures* (New Haven and London, 1985), ch. 3.

[118] Solkin, *Painting for Money*, 216.

[119] E.g. J. Crary, *Techniques of the Observer: On Vision and Modernity in the Nineteenth Century* (Cambridge, MA, 1990);L. M. Shires, *Perspectives: modes of viewing and knowing in nineteenth-century England* (Columbus, 2009).

of course.[120] George Bickham wrote a textbook for children as *The Drawing and Writing Tutor* (1730).[121] In fact, Bermingham has suggested that it was only as the politeness of art increased that its role in wider education diminished.[122]

The common 'bank' of visual skills extended to the appreciation – not just the production – of art. Peter de Bolla, Mark Hallett, Susan Siegfried and Kate Retford have explained how paintings themselves inscribed modes of viewing. They taught viewers how best to scrutinise art (cf. chap. I).[123] Paintings such as Philippe Mercier's *Sense of Sight* (Figure 1) and Joseph Wright of Derby's *An Experiment on a Bird in the Air Pump* (Figure 2) encoded the social conventions of seeing, by which one could see properly or improperly.[124] Art itself regulated early-modern visuality.

Artists themselves were aware of the importance of the trained eye. Sir David Wilkie, PRA, postulated that the eye was a "powerful...agent of intelligence" and the "connecting link" between the sitter and viewer.[125] Such a comment is not to suggest that everyone conformed to these conventions of seeing or attained the same sophistication of visual intelligence. It is merely to suggest that society (including painters) recognised that collective practices of seeing emerged, and that people – including artists, sitters and critics – tried to influence how others saw.[126]

Both the art boom and the shift in medicine toward visual inspection relied on the acquisition and training of visual skills. Doctors' and artists' visual practices overlapped inasmuch as both involved skills of close inspection, an appreciation of surfaces and

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[120] Bermingham, *Learning to Draw*, x-xi.
[121] Bermingham, *Learning to Draw*, 44.
[122] Bermingham, *Learning to Draw*, 44, 132.
[123] de Bolla, *Education of the Eye*; M. Hallett, 'Reading the Walls: Pictorial Dialogue at the British Royal Academy', *Eighteenth-century Studies,* 37, 4 (2004), 581-604; S. L. Siegfried, 'Engaging the Audience; Sexual Economies of Vision in Joseph Wright', *Representations*, 68 (1999), 34-58; K. Retford, 'The Evidence of the Conversation Piece: Thomas Bardwell's The Broke and Bowes Families (1740)', *Cultural and Social History*, 7, 4 (2010), 493-510.
[124] This broad argument is developed persuasively, barring one or two exaggerations of the differences between the sexes, in Siegfried, 'Engaging the Audience'. The *Blacksmith Shop* is discussed at 35ff.
[125] Cunningham (ed.), *Life of David Wilkie*, iii, 164.
[126] For an expanded discussion of such practices, see below, chaps. I and II.

materials, sustained bodily attention, and so on.[127] The discipline of anatomy supported the mutual development of artists and doctors alike – as it had since at least the sixteenth century (see chap. III). Medics wrote anatomical textbooks specifically for artists. Artists wrote about anatomy in art for the interest of medics.[128] Moreover, medics would have had the basic visual upbringing just discussed, while knowledge of anatomy will only have supplemented artists' rudimentary knowledge of the body outlined earlier.

This thesis suggests that portraits reveal how visual skills of art and medicine came together in day-to-day medical practice. Portraits asserted medics' professional acumen and assisted doctors' casuistry (see chaps. III and IV).[129] Portraits were used to represent what illnesses looked like, in clinical practice as in wider culture (see chaps. I, II and III). A high-degree of self-evidence was imputed to artistic representations of illness; and doctors cared about their quality. These points alone suggest it is hard to untangle art and medicine. Of course, we should not be surprised by any contemporary disciplinary enmeshing. We are investigating an age that did not think in terms of rigidly-defined, separate 'disciplines'. But we might recognise it as fundamentally 'interdisciplinary'. One way of describing this thesis is as an examination of four prominent nodes of this long eighteenth-century interdisciplinarity.

Evidence and methodology

Any interdisciplinary study – let alone a study of what we might call historical interdisciplinarity – will require a range of sources and approaches. Across mainstream

[127] Cf. L. J. Jordanova, 'The Social Construction of Medial Knowledge', *Social History of Medicine*, 8, 3 (1995), 361-381, at 376-7. The visual here encompasses not only artefactual things that can be looked at, but practices that involve looking; cf. the note on the Royal Society's Curiously Drawn conference by Alexander Wragge-Morley: http://picturingscience.wordpress.com/2012/06/28/some-thoughts-on-curiously-drawn-the-origins-of-science-as-a-visual-pursuit/; accessed 5th March, 2013.

[128] R. L. Bean, *Anatomy for the use of artists* (London, 1848), 14ff; C. Bell, *The Anatomy of Expression, as Connected with the Fine Arts* (London, 1806).

[129] E.g. S. Ashwell, *A practical treatise on the diseases particular to women* (London, 1845).

historical scholarship, visual sources are "still an alien category of evidence for those used to words".[130] This holds for the history of medicine, too. Despite a few countervailing examples, it still relegates visual material.[131] In 2007 – fully fourteen years after the "pictorial turn" was coined – Roger Cooter and Claudia Stein remarked that historians of medicine had "had no need...to heed the visual, let alone express 'anxiety' over its objects".[132] The 2011 *Oxford Handbook of the History of Medicine* – billed as "the first large scale review of the field for twenty years" – contains only five images in almost seven hundred pages.[133] Visual sources are implicitly thought of as evidence with too many interpretational pitfalls to make convincing arguments – or as simply baffling.[134]

Those who use pictorial evidence, therefore, still have to justify themselves.[135] I shall sketch out why I use portraits at all – and why I use them wholeheartedly and on their own terms, not just as a blithe way of illustrating long eighteenth-century medicine. I shall explain my debt to art history concerning how portraits are made, used and seen, what portraits 'contain' and disclose, the roles of various 'agents', and portraits' relationship with other source genres. I draw liberally from art history mainly because its duty to paintings *as evidence* prompts it to conceptualise portraits fuller – and to treat them with more care – than any other discipline.[136]

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[130] L. J. Jordanova, *History and Practice* (London, 2nd ed., 2006), 81. Cf. the essays in the special issue of *Cultural and Social History*, 7, 4 (2010).

[131] Countervailing examples include Stafford, *Body Criticism*, 34; Jordanova, *Sexual Visions*; Gilman, *Disease and Representation*; Porter, *Bodies Politic*, 10. The neglect is especially marked compared with the history of science: Kusakawa, 'Picturing Knowledge'; L. Pauwels (ed.), *Visual Cultures of Science: Rethinking representational practices in knowledge building and science communication* (Lebanon, NH, 2006; cf. also the papers emanating from the Royal Society's *Curiously Drawn* conference, 2012.

[132] On the pictorial and visual turns, see J. Tucker, 'The Historian, the Picture and the Archive', *Isis*, 97, 1 (2006), 111-120, at 112; Cooter and Stein, 'Coming into focus', 181.

[133] M. Jackson (ed.), *Oxford Handbook of the History of Medicine* (Oxford, 2011); for the billing, see http://ukcatalogue.oup.com/product/9780199546497.do#.UQgIGB2ZaSo; accessed 28th February, 2013.

[134] S. Gilman, 'How and Why do Historians of Illness Use Or Ignore Images in Writing Their Histories?', in *idem*, *Health and Illness,* 9-32, at 9.

[135] See e.g. A. B. Shtier and B. Lightman (eds.), *Figuring it out: Science, gender and visual culture* (Lebanon, NH, 2006), xvi.

[136] Baxandall, *Patterns of Intention*, 15.

It is important to separate the term portrait from more general terms of visual representation – not only to avoid category errors, but also to support the claims that the thesis makes for the particular significance of portraits. How did the long eighteenth century understand 'portraiture'?

The main criteria were 1) conscious purposeful representation and 2) an identified or identifiable sitter. By conscious and purposeful, I mean something that was specifically conceived of and specifically executed in a material form. A portrait was a product of the deliberate exercise of mental and manual skills. By an identifiable sitter, I mean that the representation resembled the sitter and corresponded with his or her supposed appearance in such a way that one would be able to say that the portrait is (of) *that* person, not just any person. In other words, a portrait, as alluded to above, is a physical index to individual person-hood and identity.[137]

Alongside this connotation, which has persisted to this day, contemporaries understood portraiture more widely. Biographies and case-histories could also be deemed portraits (see chap. I). So could representations of body fragments (see chap. III). Finally, the noun 'portrait' and the verb 'to portray' kept their general medieval connotations of close detailed delineation of a subject, although the long eighteenth-century usage of this was, it seems, much rarer.[138] (Putting these definitions together, the word 'portrait' aligned with only a fraction of the meanings of the word 'image'; image could also imply mental and verbal representations, effects of light and optics, and symbols.)[139]

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[137] Cf. A. Gell, *Art and Agency: An anthropological theory* (Oxford, 1998), 12ff. It is perhaps a moot point whether historians should consider as a portrait any representation that would have been recognised in its own time as a portrait, even if they cannot identify the person portrayed beyond doubt. Conceptually at least, I do. Not to do so would ignore, for instance, the vast array of portraits that were not specifically named but still exhibited with titles such as *Portrait of a Lady* etc.

[138] For more on this generally, see M. Pointon, *Portrayal and the Search for Identity* (London, 2013), 23; OED: "portrait" and "portray".

[139] OED: "image".

From this plural definition, it is possible to see how (visual) portraiture can be primary evidence. For one thing, portraits bear witness to past people in literally the most graphic way. Since portraits seek to communicate individual person-hood,[140] there is no reason why they cannot communicate with historians as they did to contemporaries, even if perhaps not to the same extent. Second, portraits are incarnations of contemporary understandings, interests and skills. Understanding these three elements, and putting them in their rightful contexts, allows the historian to move towards explanation. If we can identify the understanding that has gone into a portrait, then we can consider mindsets, reasoning and conscious judgment. If we can identify the interests at stake in making a portrait, then we can consider motive, cause and effect. If we can identify the skills that went into making a portrait look as it does, then we can consider habits and actual practices. Indeed, by putting these elements together, portraits have the potential to be sources "capable of explaining the imaginative reach of ideas of health, healing and sickness...how people experience...[and] react to them, and construct their significance".[141] Such experiences include medical relationships and doctors' clinical practices. To tap any such explanatory potential, it is important to recognise some crucial characteristics of portraits as historical things and as historical evidence, which affect how we might use them.

To begin with, portraits are the work of many brains and (sometimes) many hands. Agency is distributed between several people – at least the artist and the sitter and the viewer (see below), but possibly also patrons, suppliers, dealers, and so on. Such agency is driven by social conventions, interpersonal interests, individual conscious and subconscious impulses, and whatever materials and practices are available physically to make a portrait with. Getting a grip on agency is necessary if we are to bestow portraits with any explanatory powers.

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[140] R. Brilliant, *Portraiture* (London, 1991), 8; J. Woodall, 'Introduction', in *eadem* (ed.), *Portraiture*, 1-25.
[141] Jordanova, 'Social Construction of Medical Knowledge', 354.

One fruitful concept that art historians have developed for conceiving of this swirl of forces affecting agency is the 'portrait transaction' (cf. chap. III).[142] To make a portrait, a sitter will approach an artist (if he cannot or does not want to portray himself). He will have an idea of what he wants to look like and will command the artist to paint accordingly. Just as we are never satisfied with the first photo in a passport photo booth, and so look up or down and adjust the seat between shots, so a portrait sitter will exert himself as much as he can to shape the final form of his portrait. For his part, the artist will bear in mind how he likes to paint, his livelihood – i.e. client satisfaction – as well as the particular demands of the sitter. The result of the collision of interests will depend on how forcefully each pursues his interests, and which he is willing to compromise on. To borrow Joanna Woodall's metaphor, the making of the portrait will be a "perpetual oscillation" between the interests of these two parties.[143] In his celebrated *Camera Lucida*, Roland Barthes identified four different constitutive interests, which aptly capture four points between which a portrait will oscillate: 1) who the sitter thinks he is; 2) who the sitter wants others to see; 3) who the painter thinks the sitter is; and 4) what the painter wants to get out of making the portrait.[144]

Both parties are also enmeshed in value systems, including social *mores* and cultural trends.[145] Art historians assume that both parties will want the portrait to engage in these systems – to generate, support, modify or buck them. That is why scholars like David Solkin and John Barrell have searched for ideologies and cultural politics in art.[146] Such systems provide the transaction's formative contexts. Within the transaction itself – particularly the sitting – scholars have shown how they produce moments of psychological intersubjectivity. Angela Rosenthal's study of how artist Elisabeth Vigée le Brun's sittings

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142 With this term, cf. Jordanova, *Defining Features*, 140f; *eadem*, *Look of the Past*, 7, 79ff.
143 Woodall, 'Introduction', 21.
144 R. Barthes, *Camera Lucida: Reflections on Photography* (trans. R. Howard, London, 1996).
145 Brilliant, *Portraiture*, 11.
146 Solkin, *Painting for Money*; Barrell, *Political Theory of Painting*; cf. D. Fordham, 'New Directions in British Art History of the Eighteenth Century', *Literature Compass*, 5, 5 (2008), 906-17.

cut across received eighteenth-century moral norms of appropriate male-female visual contact is perhaps the best known example of this work.[147] How, too, can the artist control the hand that paints a lover's body, or a parent's?[148]

Art historians have also conceptualised how an artist will choose to paint a portrait – once Woodall's oscillation has at last reached a sort of 'suspended equilibrium', if we will. Portraits obviously vary enormously in content – not just in terms of the person depicted, but in how they are made. (Form *is* content in this respect.) How does the joint creativity of artist and sitter transform into artistic practices? I have found Michael Baxandall's concepts of brief, charge and *troc* helpful to bear in mind. Baxandall imagines a portrait – like any other art form – to be an attempted solution to a problem. That problem is his 'charge'.[149] Faced with the peculiar circumstances of his commission, he will refine his charge into a 'brief'.[150] In Baxandall's example of the Forth Bridge in Scotland, such circumstances included side-winds, railway companies' needs, previous bridge designs, and so on. As for a portrait (of person *X,* let's say), the basic questions underlying the brief are "Why *paint X*?" and "Why should I paint *X this way*?"[151]

Both charge and brief are influenced in historically contingent and specific ways: by the available colours, canvases, brushes, etc.; by conventions of style, the operation of the art market, predilections of taste, etc.; and most obviously by who the sitter is and how involved he or she got in the making process. To fulfil his side of the bargain, an artist must choose from among the tropes, materials etc. available in his culture those he would like to use. (Or he must reconfigure or redesign these tropes/materials etc. to create something altogether new.)[152] Baxandall referred to this cultural fund as *troc*.[153] As T. J.

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147 A. Rosenthal, 'She's got the look! Eighteenth-century female portrait painters and the psychology of a potentially dangerous employment', in Woodall (ed.), *Portraiture*, 147-66, at 148. Cf. M. Pointon, 'Kahnweiler's Picasso; Picasso's Kahnweiler', in Woodall (ed.), *Portraiture*, 189-202.

148 Cf. chap. I.

149 Baxandall, *Patterns of Intention*, 14-5.

150 Baxandall, *Patterns of Intention*, 30ff.

151 Cf. Baxandall, *Patterns of Intention*, 25ff.

152 Baxandall, *Patterns of Intention*, 47ff; T. Crow, *The Intelligence of Art* (Chapel Hill and London, 1999), 102; Jordanova, *Defining Features*, 47.

Clark argued in his influential *The Painting of modern life*, a culture is always seeking to redefine the limits and the coherence of different forms of representation.[154] *Troc* is subject to the vicissitudes of culture. As we will pick up below, historians have to try to perceive real features of an artwork that were within the cultural expectations, conventions, or imagined possibilities of the time.[155]

Alongside whatever general culture supplies, historians have also paid close attention to the precise skills that local practices bestow on the artist (and as we will see, on the viewer). These inform the making of a portrait. As the historian of science Otto Sibum has claimed, objects embody clues about the knowledge used to make them.[156] I find Sibum's notion of "gestural knowledge" particularly useful. This refers to the sum of skills that a practitioner has acquired in going about his day-to-day business, which he will apply to different practices. Sibum's concept allows all manner of biographical details to be brought to bear on analysing knowledge and how it gets used. For instance, Sibum has shown how James Joule harnessed his brewing skills and knowledge about yeast when trying to calculate the value of heat.[157] Simon Schaffer has similarly shown how the skills of the dyer were transferred in Stephen Gray's and Granville Wheler's demonstrations of electrical "attractive vertues" of the body in the 1730s.[158] In an art-historical context, Baxandall has shown how fifteenth-century Italian paintings corresponded with specific local dances, commercial practices and religious exercises. Such skills inform the artist's understanding of what a work of art can be.[159]

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153 Baxandall, *Patterns of Intention*, 47ff.
154 T. J. Clark, *The Painting of modern life: Paris in the art of Manet and his followers* (New York, 1985), 6.
155 Cf. P. Willis, 'Invisible Aesthetics and the Social World of Commodity Culture', in D. Inglis and J. Hughson (eds.), *The Sociology of Art: Ways of Seeing* (Basingstoke and New York, 2005), 73-86, at 76.
156 See the comments of Sibum in his conversation with Leora Auslander, Amy Bentley, Leor Halevi and Christopher Witmore in *American Historical Review*, 114, 5 (2009), 1355-1404, at 1384.
157 H. O. Sibum, 'Reworking the Mechanical Value of Heat: Instruments of Precision and Gestures of Accuracy in Early Victorian England', *Studies in the History and Philosophy of Science*, 26, 1 (1995), 73-106.
158 See S. Schaffer, 'Self-Evidence', *Critical Enquiry*, 18, 2 (1992), 327-362, at 335ff and, for an extended example of his borrowing from Sibum, *idem*, 'Experimenters' Techniques: Dyers' Hands and the Electric Planetarium', *Isis*, 88, 3 (1997), 456-83.
159 Crow, *Intelligence of Art*, 96.

These day-to-day skills will also have been developed by those who may happen to *view* a work of art. The same visual intelligence that artist and sitter blended in a portrait transaction is not only possessed by them, but by their peers as well. Baxandall coined the term "the period eye" to refer to how specific-but-commonly-practiced everyday actions fostered collective visual habits. In other words, practices and knowledge informed how viewers look at a painting. Artists were apt to heed these collective habits in order for their work to make sense to those who looked at it. Otherwise their paintings would have been nonsensical or unintelligible. Of course, as mentioned above, not everyone will have developed exactly the same set of skills, nor honed them to the same extent. And we remember that eighteenth-century society found ways to instruct looking and to privilege certain ways of looking (like connoisseurship). Nevertheless, it is important to be aware of the fundamental skills of those we might call the interpretative community of lookers.[160]

The need for this owes a lot to the general historiographical shift towards 'reception studies'. Art historians have, over the past generation or so, considered what might be called 'the audience's share' in an artwork.[161] Earlier, we spoke of a dynamic interaction between artist and sitter. As Wilkie recognised, there is equal intellectual dynamism in the relationship between the work of art and the viewer – especially at the level of meaning-making. This relationship is dynamic at an iconographical level, for instance, because it is up to the viewer to decode what motifs and allusions appear in a work. Different viewers will decode differently.[162] Anthropologically, it is dynamic because, as David Freedberg and Alfred Gell have argued, the beholder will respond to the image itself and also to the effect the image appears to have on him.[163] Meanwhile, as Michael Fried and Susan Siegfried have demonstrated, this effect is often the deliberate result of the

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[160] M. Baxandall, *Painting and Experience in Fifteenth-century Italy* (Oxford, 1975), 29ff. Diseases have their own interpretative community of lookers: see Gilman, *Disease and Representation*, 3, 7.
[161] Jordanova, *Look of the Past*, ch. 4, esp. 162.
[162] G. Rose, *Visual Methodologies: An Introduction to the Interpretation of Visual Materials* (London, Thousand Oaks and New Delhi, 2005), 200.
[163] D. Freedberg, *The Power of Images: Studies in the History and Theory of Response* (Chicago and London, 1989), xxi; Gell, *Art and Agency*, 29 (Table 1).

artist's skill. The artist will a) try to make the viewer interpret a work in a certain way or b) try to make him recognise his own 'seeing' process.[164] Numerous art scholars have also shown how the position of the viewer and the conditions in which he or she sees a work are crucial to the meanings that that work can evoke.[165] Meaning can emerge as different viewers look at a work in different spaces, too – whether in a gallery, at home among friends, at an auction, and so on. David Carrier has referred to these ongoing processes as the 'afterlife' of a work.[166]

All these insights beg the question, what exactly *is* there in a painting to see, and how can we study it? A helpful way of approaching this is to follow the lead of Bruno Latour and others and work out how a painting engages the eye by its "imaging craftsmanship".[167] We can point to choices of medium; a portrait may come in many different forms and 'types' (see above).[168] Choices of colour – especially the relation of tones and shades – are also important. Pose, setting, scale, accoutrements (including clothing) – all call our attention. Conventional motifs, and those that go against the grain of convention, may equally demand notice.[169] So might departures from an artist's typical style; they can act as entry points into how the portrait transaction is negotiated.[170] The choices of frame and immediate location can also reveal clues about the sort of attention the portrait initially wanted to garner. All these mediators – colour, motifs, etc. – have to be

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[164] M. Fried, *Absorption and Theatricality: Painting and Beholder in the age of Diderot* (Chicago and London, 2nd ed., 1988); Siegfried, 'Engaging the Audience', 49.

[165] K. Scott, 'Under the sign of Venus: the making and meaning of Bouchardon's *L'Amour* in the age of the French rococo', in K. Scott and C. Arscott, *The Manifestations of Venus: Art and Sexuality* (Manchester and New York, 2000), 69-89; Jordanova, *Look of the Past*, 87ff; D. Carrier, 'Art Museums, Old Paintings, and Our Knowledge of the Past', *History and Theory*, 40, 2 (2001), 170-189, esp. 174-5.

[166] Cf. Carrier, 'Art Museums', 176.

[167] B. Latour, 'Visualisation and Cognition: Drawing things together', *Knowledge and Society*, 6 (1986), 1-40, at 3.

[168] J. F. Kerslake, *Early Georgian Portraits* (London, 2 vols.., 1977), i, xi; T. K. Rabb and J. Brown, 'The Evidence of Art: Images and Meaning in History', in R. I. Rotberg and T. K. Rabb (eds.), *Art and History: Images and their Meanings* (Cambridge, 1988).1-7, 5.

[169] B. Latour, 'How to be Iconophilic in Art, Science and Religion?', in C. A. Jones and P. Galison (eds.), P*icturing Science, Producing Art* (London, 1998), 418-40, at 436-7; cf. Crow, *Intelligence of Art*, 6ff.

[170] M. Pointon, 'Material Manoeuvres: Sarah Churchill, Duchess of Marlborough and the Power of Artefacts', *Art History*, 32, 3 (2009), 485-515, at 488; cf. Jordanova, *Defining Features*, 164.

related together. We can try to see the logic of the whole work even if our attention is called to one particular element of it.[171]

To convey what contemporaries might have been doing with portraits, historians have to look closely and describe vividly.[172] Yet there is always a danger that we think we explain art *just* by describing it. We have to pay attention to what connects our writing about art to the art itself.[173] Avoiding catch-all stylistic descriptors, for instance, is one way of trying to steer clear of that danger. Being explicit about inferences is another. Where I infer, I have tried to trust my own eye without stretching what – by my reading and looking – I have deemed contemporaries would have thought it possible and plausible to interpret. I have also tried to bear in mind my own participation in a visual culture and what that might mean for my claims about visuality.[174] Stuart Hall sums up the hopefully pragmatic approach to visual interpretation that I adopt: "to look...at the concrete example...in relation to the actual practices and forms of signification used" by contemporaries.[175] There are additional contexts that one can set an interpretation in, the most obvious being other works by the artist one is looking at.

Analysing what one see and describes is yet another matter. David Baird argued that 'things' require certain modes of analysis. So do visual sources.[176] Thomas Crow has argued convincingly that these modes can actually be revealed in the course of describing the elements and logic of an artwork. As he explained, Meyer Schapiro's careful descriptions of the Souillac portals in Spain "demand[ed] a social history...sustained within" those descriptions.[177] Put another way, an "object invites and prefigures its analysis".[178] All this is

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[171] Latour, 'How to be Iconophilic', 424, 436.
[172] C. Haynes, 'Art History', http://www.history.ac.uk/makinghistory/resources/articles/art_history.html; accessed 7th March, 2013.
[173] Cf. M. A. Holly, 'Past Looking', *Critical Inquiry*, 16, 2 (1990), 371-396, at 387; Baxandall, *Patterns of Intention*, 1ff..
[174] Cf. Cooter and Stein, 'Coming into focus', 205.
[175] S. Hall (ed.), *Representation: Cultural Representations and Signifying Practices* (London, 1997), 9.
[176] D. Baird, *Thing Knowledge* (Los Angeles, 2004), xvii-iii.
[177] Crow, *Intelligence of Art*, 21.
[178] Crow, *Intelligence of Art*, 5.

an exercise in treating a portrait on its own terms. It is my contention that the portraits we shall look at in the following chapters ask for a (social and cultural) medical history.

Portraits might well stand alone analytically. But for the tightest analytical grip on them, we ought to recognise that they did not stand alone historically. As William Schupbach has commented, they were not "intellectually self-sufficient". Rather, they were contributions to the wider contemplation of a subject.[179] In other words, they need to be woven into the historical fabric of their time and set against other sources. For the long eighteenth century, there is particular scope to set the visual against the verbal. As Roy Porter said, these were "two sides of the same cultural coin".[180] Indeed, portraits were suffused with text; they complemented texts; text was used to describe them.[181] Pictures were not merely there to illustrate textual arguments, or to show the reality that text described.[182] Our analysis can reflect this. Treating different sources on their own terms but within the same framework or in answer to a single set of questions can yield more insights than the sum of the evidential parts.

Comparison forms part of treating different sources in the same frame. Immediate comparisons are possible – for instance with portraits by the same artist. It is also possible to compare at a higher level with the genre as a whole or even between genres – to ask how a portrait is typical or how it refers to or challenges other generic conventions (or indeed the conventions of another genre, such as autobiography). This type of analysis relies primarily on being able to detect visual clues and to chart these clues through different portrait practices. As Ludmilla Jordanova has recently pointed out, it is vital to be clear and precise about the "types of affinity" between two images or sources.[183]

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[179] W. Schupbach, *Iconographic Collections of the Wellcome Institute for the History of Medicine* (London, 1989), 18.
[180] Porter, *Bodies Politic*, 10.
[181] Cf. P. Wagner, *Reading Iconotexts: from Swift to the French Revolution* (London, 1995); Jordanova, *Look of the Past*, 195ff.
[182] Jordanova, *Sexual Visions*, 91; Gilman, 'How and Why...?', 16.
[183] Jordanova, *Look of the Past*, 222ff.

This thesis makes its arguments mainly by setting case-studies against general trends. For instance, in chapter IV, I set Alexander Morison's and Francis Sibson's publications against broader trends in both publishing and medical publishing. I find comparison by case-study particularly useful mainly because it allows for fuller contextualisation and for smaller details to assume their proper relevance. Case-studies also allow us to compare between the particular and the general. In the chapters that follow, I investigate the place of patient portraits in long eighteenth-century medicine.

Chapter I – Representing the look of diseases and illness in long eighteenth-century portraiture

Introduction

This chapter introduces how illnesses and diseases were made visible in long eighteenth-century portraiture – i.e. how they affected the material production and the reception of portraits. I examine how and why portraits might 'show' an illness. I also discuss how people might have seen illnesses in portraits, because how people saw portraits went towards how portraits 'looked'. This is essentially an exercise in probing how portraiture – and its conventions – represented the outward signs of illnesses and how people recognised those signs.

The ways in which a specific artistic genre (like portraiture) dealt with the visibility of signs of illness in this period remain to be explored.[184] Works that have discussed visible signs of illness have tended to try to recover the visual cultural 'fantasy' of illness – as per Gilman above – or they have tried to spot and diagnose conditions retrospectively.[185]

Retrospective diagnoses seek to determine what people of the past suffered. But in using today's medical standards to judge yesterday's medical issues, such diagnoses, whatever their accuracy, run the risk of being incommensurable with past categories and experience. This risk is especially acute when using visual material. How can we *see* illnesses in past visual sources, and how can *we* see them? This chapter also explores the visible manifestations of diseases and illness in portraiture. But as I shall explain, there are ways of

[184] This might be because scholars have assumed that portraits *would never* show such signs. Harriet Palfreyman has commented that watercolours of patients at London's Lock hospital "could appear almost portrait-like, *were it not* for the very obvious marks of their disease"; Palfreyman, 'Visualising Venereal Disease', 157. Emphasis added.

[185] On retrospective diagnosis, see e.g. P. Abastado and D. Chemla, 'Rembrandt's Doctors', *Journal of Medical Humanities*, 33 (2007), 35-7; V. A. Aita, W. M. Lydiatt and M. A Gilbert, 'Portraits of care: medical research through portraiture', *Journal of Medical Humanities*, 36 (2010), 5-13; and N. Hughes, M. Ramachandran and J. K. Aronson, 'The diagnosis of art: Sir George Savile, 8th baronet – the ears have it?', *Journal of the Royal Society of Medicine*, 101, 12 (2008), 6050-6.

considering the issue of visibility that would make sense to contemporaries. In any case, my aim is not strictly diagnostic. Nor I do not wish to engage in terminological debates.[186]

For me, the more historically interesting questions relate to the contemporary awareness and uses of portraits, and why portraiture was mobilised to generate meaning about illness. Why were the signs of illness painted at all? Or, indeed, why were they not? What were portraits made to express at the time? Who saw such portraits, and how did they see them? Answering these sorts of questions reveals some of the representational strategies and precise artistic mechanics that will underlie the enquiries of subsequent chapters.

As well as these broad questions, there are some more specific questions to consider. What does it mean that society developed tropes for representing illnesses? What does it matter that personal portraits presented them? Were different illnesses depicted in different ways, or was the decision simply "to show or not to show"? Did different social groups have the signs of illness depicted differently? Then there are questions about looking at portraits. How did viewers see illness in portraits? Were 'ill' portraits intended for anything other than private discreet looking?

The reward for tackling these sorts of questions is considerable. First, they offer scope to compare literary and visual representations – to examine both sides of culture's coin, to follow Roy Porter's metaphor.[187] Second, examining portraits' signs can offer insights into contemporary medical awareness, medical sensibility and visual intelligence. Third, portraits can help us to assess how illness mediated identity; it will be shown that portraits were flexible instruments of illness-affected identity-representation. Fourth, examining portraits introduces how people dealt with the 'lived' experiences of medical life, such as being marked on the body – a matter that the second chapter shall pursue.

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[186] J. Arrizabalaga, J. Henderson and R. French, *The Great Pox: The French Disease in Renaissance Europe* (New Haven, 1997); cf. L. K. Little, 'Plague Historians in Lab Coats', *Past and Present*, 213 (2011), 270-90.
[187] See Introduction.

The questions just outlined are designed to interrogate the key processes of this chapter: 'showing' and 'looking'. I argue these are pivotal to understanding how illnesses were made visible. At the simplest level, portraits 'show' whatever it is that they want to present to the viewer. Viewers, on the other hand, will govern how a portrait 'looks' by how they see it; that is their 'share'.[188] Different combinations of showing and looking rendered the signs of illness more or less visible. The term 'ill portrait' denotes a portrait which either showed a sign of illness or looked ill by virtue of a viewer perceiving a sign of illness in it.

Showing

Portraits did not necessarily divulge the facts or the legacies of illness. They were not transparent documents of suffering, symptoms or lasting signs. Indeed, as we shall see, portraits were used precisely to overturn the notions of suffering and illness (see chap. II). The incongruence between our 'knowledge' of someone's illness, and the fact that his or her portrait may not appreciably convey any sense of that illness, together suggest that portraits were flexible.[189] They need not have represented everything there was to represent – let alone faithfully, in the same way, or all the time. Visual codes enabled artists and sitters to 'show' something in a certain way. Iconography (pictorial semiotics) is therefore especially relevant to this chapter since it locates and interprets symbols and signs within the possibilities afforded by different formal techniques and stylistic/aesthetic traditions.

Showing, or presenting a look, is a complex process – both in human and artistic terms. It relies on decisions: ethical and emotional decisions about what to show and how faithfully to show it; aesthetic decisions about how to represent what is to be shown; and

[188] See Introduction.

[189] This supposed knowledge derives mainly from written sources. They could, of course, be just as flexible as portraits. This is one reason why historians need to compare both genres with the same levels of constructive scepticism.

mechanical decisions about how that representation is to be carried out. Historians can try to unravel these processes. The concepts of the portrait transaction and of charge and brief explained in the Introduction can help.

One especially prominent example from the history of medicine concerns Sir Joshua Reynolds' portrait of John Hunter, the celebrated anatomist and surgeon (Figure 4). Originally sketched with Hunter wearing a beard, seated contemplatively at his desk in a banyan, surrounded by *materia medica*, Reynolds was commanded to remove the beard for the final 'presentation' oil. Hunter's wife thought a beard did not befit the look of a gentleman of learning that Hunter intended to convey. Hunter and his wife took the decision to instruct Reynolds to alter Hunter's appearance – with all its ethical implications for a faithful likeness – because it fitted with an aesthetic and emotional decision to present Hunter as a certain type of medical practitioner. The Hunters amended Reynolds' brief. We also know that Reynolds retouched the portrait in 1789 – importantly after it had been engraved and gone public – because Hunter suffered an illness that altered his facial appearance.[190] This chapter seeks to unpick the equivalent knots of decisions that were taken concerning illness, and to explore the semiological and compositional devices that were used to realise those decisions in material form. To do this, I shall focus on illnesses that left recognisable visible marks, in particular smallpox.

This decision making cannot be expected to have been documented plentifully. But that should not necessarily deter us. No-one bothers to explain or allude to what goes without saying. Moreover, as the Introduction noted, portraits themselves offer clues about how they were made. Sensible inductions from paintings can reveal much without damaging their integrity as art or as historical artefacts – just like the careful palaeontologist can brush away dirt without damaging fossils. What is more, if we resist the urge to 'translate' them into or to subsume them under texts, then portraits can be related

[190] See W. Moore, *The Knife Man* (London, 2005), 448; on this portrait more generally, see Jordanova, 'Medical men', and Sarafianos, 'Natural History of Man'.

historically to non-visual sources in a variety of ways. The summaries of art and medicine in the Introduction help us appreciate the medical culture that conditioned responses to illness as a whole, plus the general conditions that shaped how people reacted to individual illnesses. These offer contexts for how contemporaries might have thought about showing the signs of certain illnesses – i.e. what representations would have been run-of-the-mill and which ones too explicit. They are also contexts within which to evaluate how and to what extent a portrait was 'about' the illness it showed.

Looking

If it is possible to understand what a portrait is showing, then historians can also try to reconstruct the way portraits 'looked'. That is to say, we can try and work out what was seen and how it was seen – i.e. how the visual codes of showing were deciphered. This is to distinguish between seeing and *seeing as*. How a portrait looked depended on the latter. A portrait looked ill when a sitter was *seen as* ill.

Contemporaries saw certain portraits *as* portraits of ill people and sufferers. In 1761, for instance, William Pulteney claimed that Joshua Reynolds "had made an old man [Pulteney himself, in fact] look *as if* he were in pain" (Figure 5).[191] Some likenesses, like the deathbed study by Joseph Severn of John Keats, were understood as *the* 'ill' likeness (Figure 6). In Keats' case, they were compared with other portraits that showed him in the flush-pink of rude health to make a point about his character (cf. chap. II).[192] So the visual devices of showing, however explicitly or implicitly they were manifested, could be understood. It is evidence of this sort of understanding that the second part of this chapter explores.

[191] Cit. Kerslake, *Early Georgian Portraits*, 15. Emphasis added.
[192] J. Najarian, *Victorian Keats: Manliness, sexuality, and desire* (Basingstoke, 2002), e.g. 44. See also below.

The Introduction showed how eighteenth century society was visually intelligent, not blind to portraiture. Michael Baxandall's and Otto Sibum's concepts of the "period eye" and "gestural knowledge" allow us to grasp this intelligence and the painterly responses to it. Accustomed to the notion of transferrable skills, it seems patent to us that someone would use previously acquired experiences and that the behaviour of one's livelihood would carry over into other aspects of one's life. Yet if historians can grasp how and why different skills and methods were transferred, then they can begin to show the intimate and organic relationship between different cultural domains – crucially, in ways that would make sense to contemporaries.[193] Another potential analytical benefit of such concepts is their recognition of different levels of individual and common mindsets. There is no need to try to force cultural patterns on the endless variety of contemporary cases. This is especially helpful when analysing portraits that blend the conventional with the unique and (obviously) individualising. Baxandall's and Sibum's insights usher us away from arcane art theories and encourage us instead to pay attention to general sights, sounds and sensibilities that early modern people would have absorbed, as well as (quite literally) the tricks of the trades. Space prevents such a diversion, but there are still ways in which we can assess looking.[194]

First, we have to bear in mind our evidence pool. Diaries and personal literature, for instance, will offer glimpses of how contemporaries saw things. Fanny Burney and Horace Walpole commented on paintings almost everywhere they travelled. We just have to bear in mind that diaries will not illuminate the basis for judgments. Diarists tended to jot down preferences or instincts rather than reasoned iconographic critiques. Unlike Sibum's and Schaffer's natural philosophers who conducted written experiments and left

[193] In a medical example, Christopher Lawrence has considered how classical learning and clinical science were blended features of later-nineteenth-century doctors' knowledge; Lawrence, 'Incommunicable Knowledge'.

[194] No one, then or now, has found enough time or room for a history of the trades – not Bacon, not the early fellows of the Royal Society, not the *philosophes* behind the *Encyclopédie*. Alexander Murray's labyrinthine *Reason and Society in the Middle Ages* (Oxford, 1974) is a brilliant example of the sort of diversions that need to be made to trace these sorts of understandings.

written arguments of their methods and conclusions, diarists left no such base material from which we can trace other concerns. It is doubtful, too, whether they will elucidate the cognitive processes that allow us to track a past experience or a tacit cultural assumption that influenced a way of seeing. However, any written evidence of 'seeing as' will have broken the rule of taciturnity. If someone declared that they saw something as '*x*' or '*y*' or that something appeared *as* '*a*' or '*b*', it was, literally, remarkable. Indeed, contemporaries' noting down their perceptions suggests points of discursive slipperiness or innovation. Looking ill, for instance, could take on metaphorical significances (cf. chap. II).

A second 'way in' to looking is via a cultural history of observation and criticism. We ought not to consider the issue of looking as though it could only be evidenced by individuals' perception and/or from within a piece of art. This is because looking and responding to images were culturally 'managed'. The ability '*properly*' to observe and scrutinise paintings was keenly fostered in all sorts of settings in our period – from the gallery to the garden.[195] Peter de Bolla has shown how paintings taught viewers how to "overlook" as well as how to be a spectator.[196] Susan Siegfried has pointed out differences between male and female viewing.[197] Mark Hallett, meanwhile, has demonstrated the widely-appreciable visual logic of display at early Royal Academy exhibitions, as well as how portraits – often massive and brightly coloured – vied for viewers' attention.[198]

Besides artworks themselves, periodicals and 'textbooks' like Daniel Webb's *Beauties of Painting* (1760) and John Potts' *The Art of Drawing and Painting in Water-colours* (1788) also primed their readers' faculties.[199] The *Spectator* versed its readers in "conversing" with a picture, too. Cosmetti's *Polite Arts* (1767) advised on the correct distance from which to view a painting. *The Connoisseur* tried to make new connoisseurs, not just amuse existing

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[195] Cf. Freedberg, *Power of Images*, 429-35.
[196] de Bolla, *Education of the Eye,* 63ff.
[197] Siegfried, 'Engaging the Audience'.
[198] Hallett, 'Reading the Walls'.
[199] A full list of such periodicals has been compiled by H. E. Roberts, 'British Art Periodicals of the Eighteenth and Nineteenth Centuries', *Victorian Periodicals Review*, 9 (1970).

ones. William Ray has shown that, in France, even publications that discredited connoisseurship still wrote in the jargon of connoisseurial appreciation, and so (perhaps inadvertently) initiated readers into the elaborate technical descriptions and emotional responses they were supposed to avoid.[200] Tobias Smollett's Mr Bramble might be an English example of someone who disclaimed against critical powers he knew he really possessed.[201] Commonplace books, those widely filled repositories of intellectual anecdotes, often had a section called "The Knowledge of Signs" – especially Locke-inspired ones.[202] Moreover, the *New Commonplace Book* of 1799 was billed as a particularly "useful & agreeable Companion...for the Man of Observation".[203] Indeed, the ability to comment effortlessly on painting was a part of the flourishing culture of politeness and sensibility.[204]

This broad history tells us that audiences and paintings were in dialogue about how to look. Painters and other arbiters of taste were trying to fashion people's looking experiences. Art itself and art criticism were their means. Seeing something in a certain way was not a culturally neutral act.

Smallpox

This chapter's case-study of 'showing' examines portraits of known sufferers of smallpox. So named originally to distinguish it from the Great Pox (syphilis), smallpox was a highly contagious disease that attacked the blood vessels. Smallpox is known in our time as a disease that was declared universally eradicated over 30 years ago. But for most of the documented past, it was a widely-feared menace, so feared that even fear itself was thought

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[200] W. Ray, 'Talking About Art: The French Royal Academy Salons and the Formation of the Discursive Citizen', *Eighteenth Century Studies*, 37, 4 (2004), 527-552, esp. 541ff.
[201] B. Denvir, *The Eighteenth Century: Art, Design and Society 1689-1789* (London, 1983), 133-4.
[202] L. Dacome, 'Noting the Mind: Commonplace Books and the Portrait of the Self in Eighteenth-Century Britain', *Journal of the History of Ideas*, 65, 4 (2004), 603-25, esp. 614.
[203] Dacome, 'Noting the Mind', 619.
[204] Cf. Solkin, *Painting for Money*; P. M. Harman, *The Culture of Nature* (Cambridge, 2003), 237, 254ff.

to infect the frightened.[205] It took countless victims. As many as a fifth of all deaths in the first half of the eighteenth century was linked to smallpox.[206] Alexander Hamilton commented pessimistically that even if a quarter of all smallpox victims died, "the rest were either much disfigured, rendered blind, or had complaints in consequence of the disease which proved the cause of a lingering death."[207] In 1819, Sir Gilbert Blane, physician of the Hospital for the Indigent Blind, noted that fully two thirds of those presenting to apply for relief had lost their sight to smallpox.[208] It is no wonder that the celebrated physician William Cullen dwelt at length on what doctors should do in case of smallpox infection in his *First Lines of the Practice of Physic* (1777, 1783).[209] It would have been as relevant to medical practice as a weather forecast is to farming.

Contemporaries identified many strains of smallpox. In 1780, Charles Roe explained ten.[210] Smallpox was often regarded as an inflammatory fever, yet distinctions were made according to the appearance, longevity and eventual result of infection. A basic distinction was made between 'distinct' and 'confluent' smallpox according to whether blisters were separate or conjoined. Further distinction was made according to how and where on the body the blisters ran together: Sir Richard Blackmore identified a middle class of smallpox that entailed blisters running together on the face but not on the hands and body.[211]

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[205] A classic example is J. Woodward, *The State of Physick and Diseases* (London, 1718). See also Shuttleton, D. E. Shuttleton, 'A Culture of Disfigurement: Imagining Smallpox in the Long Eighteenth Century', in G. S. Rousseau, M. Gill, D. Haycock and M. Herwig (eds.), *Framing and Imagining Disease in Cultural History* (Basingstoke, 2003), 68-91, at 82.

[206] Smith, *Speckled Monster*, 16; J. Landers, *Death and the Metropolis* (Cambridge, 1993), 154-5; S. R. Duncan, S. Scott and C. J. Duncan, 'The dynamics of smallpox epidemics in Britain, 1500-1800', *Demography*, 30 (1993), 405-23.

[207] A. Hamilton, *A treatise on the management of female complaints, and of children in early infancy* (Edinburgh, 1792), 482.

[208] Smith, *Speckled Monster*, 19.

[209] The restorative treatment of smallpox before vaccination tended to be based on one of two regimes. Either the patient was subjected to sweating with hot bandages, blankets and alcohol in order to evacuate the disease as well as open the pores and force out the pus; or the patient underwent a 'cooling' regime with exposure to bracing air and water, and with a diet full of watery foods and cool liquids. Quarantine was also fairly standard.

[210] C. Roe, *A treatise on the natural smallpox...* (London, 1780), 3ff.

[211] R. Blackmore, *A Treatise upon the Small Pox, in two parts...* (London, 1723), 24.

Importantly, very visual language – the language of artistic practices no less – was used to differentiate between bouts. Take Blackmore again: in a milder form, "they [pustules] sometimes stay long enough to leave Impressions or Prints in the Skin"; in the severest confluent forms, the pustules were "often more elevated and bold...swell the face very much, and turn by degrees to a dark brown Crust or general scab...sometimes of a dull, leaden Colour"; while in less severe confluent forms the face "grows pale, and sometime as white as a sheet" or might "only turn the Skin into the Likeness of an old Piece of Parchment, or dull Russian *Leather*".[212] The poet and smallpox sufferer William Thompson also wrote of "swelling *emblematically* bold".[213] Indeed, doctors were keen to try to learn about smallpox by the visual effects they produced. In 1802, George Kirtland produced colour charts and schematic drawings to help doctors explain them (Figures 7-9).[214]

If the strains of the disease were identified by their visual properties, then the patient's symptoms were, too. Initial symptoms tended to be recorded with the straightforward language of physical effect. Simon Mason, for instance, described the "usual Symptoms of Heavyness, Pain in the Head, Back, Limbs &c., with Sickness, Reaching to Vomit, a Heat and Thirst...and...a quick full Pulse".[215] But then, as the disease progressed, visual effect infuses into descriptions. Charles Roe paid special attention to the visual effects on the patient's face.[216] Thompson likened the darkened scabby face to the rough bark of a tree: it was "One black-incrusted bark of gory boils".[217]

It was the end product of these symptoms that was most often remarked on. Pockmarks, or pits, were basically scars left after the pustulent blisters embedded in the skin had died down. As scars, they were permanent visual relics of illness and suffering. If

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[212] Blackmore, *Treatise...smallpox*, 19, 28, 30, 31.
[213] W. Thompson, *Sickness: A Poem, in Three Books* (London, 1745), bk. 1, l. 324.
[214] See Beier, *Sufferers and healers*, 78. Kirtland's 30 watercolours of the progress of smallpox are in the Wellcome Library.
[215] S. Mason, *Practical observations in physick*... (Birmingham, 1757), 184.
[216] Roe, *Natural smallpox*, 3ff.
[217] Thompson, *Sickness*, bk. 2, l. 202.

there were as many sufferers as historians have suggested, then being "seam'd with scars" was not at all unusual.[218]

Their permanence could be advantageous. They were a proof for prospective domestic servants that they had been infected and were therefore not contagious.[219] JPs sought to catch highwayman Dick Turpin by warning people they were looking for a severely pockmarked man (Figure 10).[220]

However, revulsion was more common. Pockmarks disfigured and appalled the eyes. Daniel Phillips' *Dissertation of the small pox* (1702) referred to such "foul scars and pits in the skin" that branded a smallpox survivor.[221] The (London) Smallpox Hospital governors' report for 1760 described smallpox as "so frightful, even in its first appearance", while Robert Walker pointed out that after ensuring a patient would not die, the physician's "next concern will be, to preserve the face, as much as possible, from deformity, more especially that of his fair patients."[222] One of the arguments that Alexander Hamilton made in favour of inoculation was that it would spare children from "blemishes which may make them miserable during the whole period of their existence".[223]

Disfigurement could entail a loss of social esteem or outright ostracism. If men feared smallpox for their lives, women feared it for their beauty.[224] Indeed, the notions of spoilt and lost beauty were frequently invoked. Samuel Pepys thought Lady Richmond would be "wholly spoiled" by the pox.[225] Lost beauty jeopardised marriage: Lady Elizabeth

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218 Cit. Stafford, *Body Criticism*, 160.
219 Smith, *Speckled Monster*, 20.
220 *London Gazette*, 18th-22nd February, 1735.
221 Cit. R. A. Anselment, 'Smallpox in Seventeenth-century English Literature: reality and the metamorphosis of wit', *Medical History*, 33, 1 (1989), 72-95, at 81.
222 F. H. K. Green, 'An eighteenth-century small-pox hospital', *British Medical Journal*, i (1939), 1246; R. Walker, *An inquiry, into the small-pox...* (London, 1790), 381.
223 Hamilton, *Treatise...female complaints*, 485.
224 F. Nussbaum, *The Limits of the Human: Fictions of Anomaly, Race and Gender in the Long Eighteenth Century* (Cambridge, 2003), ch. 4; J. Campbell, 'Lady Mary Montagu and the "Glass Revers'd" of Female Old Age', in H. Deutsch and F. Nussbaum (eds.), *Defects: Engendering the Modern Body* (Ann Arbor, MI, 2000), 213-51.
225 Cit. Anselment, 'Smallpox in Seventeenth-century Literature', 83.

Montagu, in a widely reprinted letter, wanted a husband who would be constant "till my face is wrinkled by age, or scarred by the small pox".[226]

Another part of the loss of esteem was the negative implications for one's character. Physical disease could imply some distortion of character or spirit – an assumption we shall pursue in the next chapter. Smallpox's assault on character is nowhere better demonstrated than in the fact that Laclos' pocky villainess in *Les liaisons dangereuses* was left with "her soul now on her face".[227] Men, by contrast, could profit from withstanding a bout of smallpox: they could be deemed persevering, determined and even manlier for surviving with nothing but toughened features.[228] Writing about a man's pockmarked body, for instance, William Thompson claimed that

> ...the human body, thus
> Enamel'd, not deform'd, from sickness rage
> More manly features borrows, and a grace
> Severe, yet worthier of its sovereign form.[229]

William Hammond, in a poetic epistle to Thomas Stanley, mused of his friend that

> ...nature hath so clean thy prison made,
> What, though she pit thy skin? She only can
> Deface the woman in thee, not the man.[230]

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[226] Elizabeth Montagu to the Duchess of Portland, 11thMarch, 1738; in M. Montagu, *The Letters of Mrs Elizabeth Montagu* (Boston, 3 vols.., 1825), i, 24.
[227] Anselment, 'Smallpox in Seventeenth-century Literature', 83; Shuttleton, *Smallpox and the Literary Imagination*, ch. 5.
[228] Cf. Shuttleton, *Smallpox and the Literary Imagination*, 140.
[229] Thomson, *Sickness*, bk. 2, ll. 365ff.
[230] W. Hammond, 'To Thomas Stanley', in *idem*, *Occasional Poems* (ed. R. Triphook and J. Major, London, 1816), 43.

It says something of pocked men's immunity from character assassination that William Hay, taunted for his hunched back, wondered why people did "not laugh at my Face...for being harrowed by the Small Pox". [231]

The history of smallpox in England in the eighteenth century has been largely confined to three enquiries: first, 'progress-focussed' studies of Edward Jenner's discovery of vaccination in 1798;[232] second, studies of inoculation;[233] and third, studies of the effect of smallpox on the literary imagination and cultural psyche.[234] The effect of smallpox on art and *vice versa* has been decidedly understudied. In 1994, Marcia Pointon interpreted Lady Montagu's portrait in Turkish garb as an exercise in re-empowering the "damaged self as [a] sexualised female body".[235] Besides this article, only an appendix in David Shuttleton's 2007 book on *Smallpox in the Literary Imagination* has given any sustained thought to the matter.[236]

This lacuna is rather puzzling for a couple of reasons. First, contemporaries, including medics, readily responded to smallpox in aesthetic terms and in aesthetic ways, as we have seen. The second reason is that historians have long been aware that smallpox triggered visual responses. Although cartoons referring to smallpox really only appear post-Jenner (perhaps because it was just too deadly to make fun of it),[237] historians have implied

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[231] W. Hay, *Deformity: An Essay* (London, 1753), 35.

[232] See e.g., H. Bezin, *The eradication of smallpox: Edward Jenner and the first and only eradication of a human infectious disease* (trans. A. and G. Morgan, San Diego and London, 2000); D. Baxby, *Vaccination: Jenner's Legacy* (Berkeley, 1994); G. Williams, *Angel of Death: the story of smallpox* (Basingstoke and New York, 2010); P. J. Pead, *Vaccination rediscovered: the new light in the dawn of man's quest for immunity* (Chichester, 2nd ed., 2006); A. A. Rusnock, 'Catching Cowpox: The Early Spread of Smallpox Vaccination, 1798-1810', *Bulletin of the History of Med*icine, 83, 1 (2009), 17-36.

[233] P. E. Razzell, *the conquest of smallpox: the impact of inoculation on smallpox mortality in eighteenth-century Britain* (Pittsburgh, 2003); D. C. Brunton, 'Pox Britannica: smallpox inoculation in Britain, 1721-1830', Uni. of Pennsylvania Ph.D. thesis, 1990; S. Fenno, "'An Experiment Practised by only a few ignorant women": Lady Mary Wortley Montagu, the smallpox inoculation and the concept of Enlightenment', in M. Choudhury and L. J. Rosenthal (eds.), *Monstrous dreams of reason: body, self and other in the Enlightenment* (Lewisburg, 2002), 85-109; I. Grundy, *Lady Mary Wortley Montagu: comet of the Enlightenment* (Oxford, 1999), 209ff.

[234] Anselment, 'Smallpox in Seventeenth-century Literature'; Shuttleton, *Smallpox and the Literary Imagination*.

[235] M. Pointon, 'Killing Pictures', in Barrell (ed.), *Painting and the Politics of Culture,* 39-72, at 70; cf. Grundy, *Lady Mary Wortley Montagu*, 202f.

[236] Shuttleton, *Smallpox and the Literary Imagination*, 210ff.

[237] Cartoonists Gillray and Cruikshank both sent up supporters and opponents of vaccination in the early nineteenth century; but there is a decided dearth of cartoons and satirical matter before then. With this, cf. S.

other visual responses. Aaron Santesso rightly claimed that "smallpox was *an everyday sight*", but did not follow through the implications of seeing and looking at smallpox.[238] Shuttleton's summary of Barbara Stafford's and Steven Connor's work concluded that "*writers* felt compelled to confront this...*high-visibility* disease and in doing so *gave it a face*".[239] Shuttleton remarked, moreover, that the "grotesque, repulsive *face* of smallpox undoubtedly posed an aesthetic challenge."[240] But text was Shuttleton's main domain.

Nevertheless, Shuttleton and the 'literary approach' need not be abandoned by those seeking visual manifestations of smallpox. Indeed, there is great scope to consider how the literary actually interacted with the visual. The development of imagery is a case in point: what is the relation between the visual and textual images a society conjured? Answering this will help us tackle our big question about what it means for a society to develop visual tropes for depicting a disease and to do it through personal portraits (rather than, say, cartoons). So it is worth taking some of Shuttleton's cases as our starting points and using them to interrogate smallpox and the visual imagination.

William Thompson

In the case of William Thompson (1711/2-66), one portrait is approached in a number of ways. His case demonstrates how an ill portrait gains meaning by its relation to a text that is itself about the disease shown. Thompson was a vicar, first in Oxfordshire and later in Ireland. He appeared in Shuttleton's volume primarily as the author of *Sickness: A Poem in Three Books* (first ed. 1745), an example of 'autopathography'.[241] Written during Thompson's

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Nunn, "'Wonderful effects!!!": Graphic satires of vaccination in the first decade of the nineteenth century', in D. M. Turner and K. Stagg (eds.), *Social Histories of Disability and Deformity: Bodies, Images and Experiences* (London, 2006), 79-94.

[238] A. Santesso, 'Lachrymae Musarum and the Metaphysical Dryden', *Review of English Studies*, 54, 217 (2003), 615-38, at 620. Emphasis added.

[239] Shuttleton, *Smallpox and the Literary Imagination*, 3. Emphasis added.

[240] Shuttleton, *Smallpox and the Literary Imagination*, 7. Emphasis added.

[241] Shuttleton, *Smallpox and the Literary Imagination*, 46ff.

convalescence, with Christ his Physician, *Sickness* describes vividly his bout of smallpox and how one should bear any illness with patience and fortitude.

Sickness is very visual. The personification of smallpox as a 'fury' gives it a dramatic appearance and suggests that it had certain looks:

> The last [fury], so turpid to the view, affrights
> Her neighbour's hags, Happy herself is blind,
> Or madness wou'd ensue; so bloated-black,
> So loathsome to each sense, the sight or smell,
> Such foul corruption on this side the grave.
> *Variola* yclep'd; ragged, and rough.[242]

Unfortunately, only one portrait of Thompson survives (Figure 11). It is an anonymous line engraving of Thompson "Aged 47". This inscription would date the portrait to 1759, some fourteen years after the first publication of *Sickness*, and two years after the publication of the third volume. Nevertheless, no date is marked, so we cannot tell for sure whether the engraving was a later printing of an earlier-taken likeness. The portrait depicts Thompson in half length, wearing a plain dark-coloured shirt, a coat with a tightly-wrapped neck-tie and a white powdered wig. Thompson gazes just off to his left; the angle of his face accentuates his apparently bent aquiline nose.

We notice, from the contrast of the background and the way the hatches of the breast panel and coat-sleeve are lighter on his right side, that light was cast from left to right. This brings his right cheek into clear view. It is heavily pockmarked. The decision to portray Thompson in this particularly open view – whether or not in order to show his pockmarks – ought not to surprise us. The slightly-angled view whereby the head is turned to around fifteen to thirty degrees off the perpendicular and which avoids the viewer's gaze

[242] Thompson, *Sickness*, bk. 2, ll. 232ff.

is typical of contemporary frontispieces (and half-length portraiture in general).[243] Since we cannot inspect his left cheek, we cannot determine whether it is more or less pocked than the right one. I do not wish to assume that he would have chosen to depict the least-pocked cheek, and am mindful that engravings, when they are printed, reverse the 'original' view of the sitter. (No original is extant.)

Nonetheless, this portrait does not put the scars into the shadows, but rather exposes them to the light, the artist and the viewer. At first glance, there is nothing else that showing the pockmarks can tell us, and nothing to align the portrait with the sitter's poem or to imply that the portrait is 'about' smallpox. We cannot even say with any confidence – even from the very suggestive timing of its production – whether the portrait was made to commemorate Thompson's final release from affliction. However, certain links are suggested and are worth pursuing.

First, if we grant that the portrait is a frontispiece, we can safely say that it should have been a part of the overall production of the poem. It would stand alongside the text and be consumed as part of the same 'package' as the text. Together, the poem and the portrait testify to the disease and its terrible symptoms. As Thompson says in *Sickness*, "I have just taken notice of the progress of the small pox, as may give the reader some small idea of it, without offending his imagination."[244] Indeed, the poem is all about showing, about persuading readers of the image of the disease so that their eyes cannot doubt its appearance. After all, as Thompson exclaims: "Sight [is] all expressive!"[245] And elsewhere he writes "What odious change, / What metamorphose strikes the dubious eye?"[246] His portrait helps to answer this very question. It supplements his written 'autopathography' by

[243] I assume, as Shuttleton also does, that this was intended as a frontispiece. Although corroboration has proved impossible, the oval frame, the banner title-piece and the nib and book that are discernible in the top icon, all point toward that deduction. On frontispieces generally, see J. Barchas, *Graphic Design, Print Culture, and the Eighteenth-Century Novel* (Cambridge, 2003).
[244] Cit. Shuttleton, *Smallpox and the Literary Imagination*, 49.
[245] Thompson, *Sickness*, bk. 3, l. 341.
[246] Thompson, *Sickness*, bk. 2, ll. 190-1.

offering the reader a realistic, unquestionable (but inoffensive) idea of the signs of his suffering – neatly packaged into the conventional frontispiece format.

Second, following on from pointing out his desire to inform the reader, we also know that Thompson wrote his allegory during his recovery in order to convey a moral *instruction*. *Sickness* specifically presents smallpox as a test of faith, which one might pass by the salvation of the heavenly Physician.[247] Indeed, Thompson explains that instruction is part of the punishment of smallpox. It is able to teach a moral lesson by its ability to convey the horror of illness. This it does through the eyes – by people looking:

> A sickly taper, glimmering feeble rays
> Across the gloom, makes horror visible,
> And punishes, whilst it informs, the eye[248]

Thompson's portrait, with his face laid bare for all to see, thus acts as a stark warning to his readers about the perils of smallpox. Although perhaps gruesome to behold, it informs by making those perils visible. Moreover, by depicting himself with indelible scars, which he cannot deny, he presents himself as a believable and undeniable author – i.e. one worthy of giving moral instructions. The moralistic nature of smallpox literature has been remarked on, but it seems that pictorial means were used didactically, too, to put a moral point.

The third connection is Thompson's comparison with Job, the biblical sufferer. Thompson likens his tribulation directly to Job's. Thompson invoked the look of the illness and its embodiment:

> One black-incrusted bark of gory boils;
> One indistinguish'd blister, from the soal
> Of the sore foot, to the head's sorer crown.

[247] Shuttleton, *Smallpox and the Literary Imagination*, 46.
[248] Thompson, *Sickness*, bk. 1, ll. 355-7.

JOB's punishment![249]

Job, of course, provided him with an archetype of patience and an extension of the didactic mode. But the association of Job specifically to smallpox was not made unthinkingly. To begin with, whereas Job's punishment had often been thought to be leprosy, many early-eighteenth-century ecclesiastics thought that Job's smiting with boils was in fact a rash of smallpox pustules.[250] Edmund Massey's 1727 sermon against inoculation made the link most explicitly.[251] Moreover, in many works in this period, Job was characteristically presented a) as someone who allows others to identify intimately with illness but b) as someone who gets others to see how *he* interprets suffering.[252] Accordingly, self-identification with Job's suffering prompts the reader/viewer to identify very personally with Thompson's illness, but on Thompson's own terms – a point that chimes with Sander Gilman's remark that images seek to control perceptions of diseases.[253] We know that *Sickness* was a personal testament to smallpox suffering. The historically contingent and precisely-situated allegorical potential of Job suggests a reason for using a personal portrait to bolster the representation.

Pictorial representations of Job increased in number as the early-modern period progressed and were, by the early eighteenth century, being made by prestigious artists such as Rubens and prestigious engravers like the royal engraver, Simon François Ravenet (Figure 12).[254] Moreover, rather than focussing on Job's relationship with his friends, artists increasingly focussed on the signs of his suffering. While only two such images are catalogued on the database of *British Printed Images to 1700*, many more are extant that can

[249] Thompson, *Sickness*, bk. 2, ll. 202-5.
[250] On Job and leprosy, and leprosy in art in general, see Boeckl, *Images of Leprosy*, esp. 55-7.
[251] Shuttleton, *Smallpox and the Literary Imagination*, 10. For more on the battle over the interpretation of Job, in particular on William Warburton, see J. Lamb, *The Rhetoric of Suffering: Reading the Book of Job in the eighteenth century* (Oxford, 1995), 8ff.
[252] Lamb, *Rhetoric of Suffering*, 36f., 214-8.
[253] Gilman, *Picturing health and illness*, 32, cit. Palfreyman, 'Visualising Venereal Disease', 15.
[254] See WL57051i.

reliably be dated to the eighteenth-century down to 1759.[255] A large etching by E. Nunzer (c. 1733) shows Job in rags with spotted skin, suffering the boils that Satan afflicted him with (Figure 13). Job strikes a similar pose to Thompson, presenting the same cheek to the viewer. Although part of Job's cheek is covered by his beard, the sharper etches within the hairs show the protruding boils on his face. George Minnikin's quite primitive stencil and woodcut print also displayed Job pocked with boils (Figure 14).[256] Job also appeared afflicted, albeit less densely, with sores in Franz Aspruck's *Allegorical and sacred subjects, and hermits* (c. 1740) under the heading of 'Patientia', precisely around the time Thompson was penning his verse (Figure 15).[257] As mentioned, this representation would chime with Thompson's wider didactic strategy of making smallpox a test-case of patience.

Representations of the pocked Job were circulating at the very time when Thompson was suffering his own pox. They were being allied to various themes, including, most obviously, patience. Thompson's portrait builds on these depictions that focus on the skin-level suffering. The frontispiece acts as a visual equivalent of his poem's self-identification with Job. It distils the essential elements of the text. If the identification with Job was a key literary strategy for Thompson, which enabled him to borrow from a large stock of biblical imagery and a well-known tale, then the frontispiece served that end, too. It appeared designed to conform to the usual frontispiece style but also subtly to pick up on a tradition of the depiction of the man with whom Thompson compared himself. The frontispiece presaged and fore-grounded allusions that would become sharper and more explicit as the poem was read. Crucially for our purpose, the least we can say is that the representation of the signs of health in portraiture co-existed with text in Thompson's instructive self-portrayal of the trials of smallpox.

[255] http://www.bpi1700.org.uk/index.html; accessed 27th June, 2012.
[256] BM2004.0630.22.
[257] WL579390i.

Humfrey Wanley

The case of Humfrey Wanley (1672-1726) allows us to pursue the links between portraits and life experiences. In this example, three portraits are analysed for the varying extent to which they depict smallpox scarring. All three depicted Wanley as scarred; but subtle differences in the composition and circumstances of the portraits allow us to question further how important the life and work of a man was to his depiction as a sufferer. Looking at Wanley's portraits in turn suggests that the focus of each portrait had a bearing on the 'representability' of his pockmarks.

Wanley is best remembered as an antiquarian of early English texts and as the librarian to those bibliophile collectors, Robert and Edward Harley, respectively 1st and 2nd earls of Oxford. Wanley was portrayed five times in three different likenesses by the same artist, Thomas Hill. (One was twice copied.) Hill was a middle-of-the-road portraitist of well-to-do society, known primarily through his paintings.[258] Many were portraits of friends and associates of the Lords Oxford.[259]

Indeed, Wanley's first portrait was commissioned by and for Lord Oxford. It was finished in December 1711 (Figure 16). A half-length, Wanley is depicted at his desk in a setting made unidentifiable – but conventional – by a large red drape which cascades down the right of the canvas behind the sitter. Wanley props up a large tome with his right hand, while his left hand appears to scan the left page. This book is in fact Wanley's own *Book of Specimens* – an anthology of facsimiles of various Greek, Latin and Anglo-Saxon manuscripts. It is painted open at a passage from St. Matthew's gospel. Accoutrements on and in front of the desk reinforce the immediate impression that this is a portrait of an antiquarian and literary scholar: the Guthlac Roll (a twelfth century account of that saint's

[258] His entry in the DNB is rather sparse and work-driven.
[259] DNB.

life); a stone with a runic inscription; and a vase borrowed from the collection of Harley's fellow enthusiast, John Kemp.[260]

Wanley's body is turned to the side, and so looks at the viewer over his left shoulder. In this process of turning, he presents his left cheek. It is pale and pocky. Dabs of heavy off-white paint are flecked onto the chin. This distinctive mark will recur in both later likenesses, as we shall see. In this one, however, another white fleck is noticeable to the left of his left eye socket. This, a large pockmark, begins a circle of bumps that descend down the cheek, round under the left side of his neck below the jaw bone, and back up, joining the circle precisely where his cap-line begins. This grouping of scars is presumably what prompted Thomas Dibdin – Wanley's equivalent as Lord Spencer's librarian in the early nineteenth century – to comment on the Bodleian version of this portrait, copied in 1716, that Wanley was "absolutely peppered with variolous indentations".[261] Wanley's scars are only so detailed in the 1711 likeness. By 1717, the circle appears 'blocked in'.

Noticing this variation enables us to make a move toward the overall analysis of the 1711 portrait. As a whole, it operates according to a scheme of intersected curves and straight lines. The straight line of the edge of the desk pierces the curves of the drape and the (round) stone. The straight line of Wanley's cap cuts into the circle of his pockmarks. This scheme is most evident in the middle of the portrait, where the two curves of Wanley's arms frame the tome. Within this arc, the four lines of Wanley's gold sleeves and buttonholes themselves create a circle, with each line pointing toward the central tome. Wanley's *opus magnum* seems as focal to the portrait's composition as Wanley himself; indeed, "accessories intrude...upon the attention and, to a certain degree, detract from the

[260] www.trin.cam.ac.uk/chartwww/antiquaries.html; accessed 21stDecember, 2011. For Kemp's loan, see Harley to Wanley, 23rd March, 1720/1, reprinted in H. Wanley, *The Diary of Humfrey Wanley 1715-1726* (ed. C. E. Wright and R. E. Wright, London, 2 vols.., 1966), i, 96.
[261] T. F. Dibdin, *Bibliomania – or Book-Madness* (London, 1842), 458, n.

importance due to the principal figure."[262]Stating this would be entirely in keeping with the commissioner, Lord Harley's predilection for literary "accessories".

Let us pause this train of analysis for the moment and compare the other two likenesses. The 'middle' likeness was captured in two portraits in 1717 (Figure 17). The angle of the pose closely resembles Thompson's above; it was an entirely conventional posture. This pose, like that of the 1711 portrait, presents the left cheek, only not as openly or as 'performatively' – there is no sense of Wanley's turning to meet the painter's or viewer's gaze. The distinctive scar to the left of Wanley's lip – rendered in off-white in 1711 – is far more sallow. There is also another large (single) scar towards the ear at the back of the cheek. The whole visage is depicted with a much greater ruddiness than in 1711. Indeed, there is a glossiness to the paint charting the face that is absent from the earlier, more pallid rendition. Perhaps these details combined to prompt Dr Arthur Charlett to let Wanley know that "Mr Denison does not think it anyways flatters you; it seems to shew more of the Depth and Sagacity of your mind than the features of your Countenance".[263]

Wanley's final portrait was taken in 1722 (Figure 18). It is a three-quarter length portrait that depicts Wanley sitting leaning comfortably back, his mouth breaking into a relaxed smile. (Judy Egerton has compared Wanley's demeanour to that in William Hogarth's 1740 portrait of Captain Thomas Coram, often deemed a pioneer of the relaxed satisfied pose.)[264] This portrait of Wanley was, like the first, commissioned by Harley. Yet unlike the first, it was not to stay with Harley; instead it was to be given to Johann Schumacher. Schumacher was a fellow lover of antiquities who had communicated at length with Wanley – as a friend as well as a librarian – on all sorts of literary and antiquarian matters.[265] Harley also commissioned Hill to portray Schumacher.[266]

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[262] G. Scharf, *A Catalogue Raisonné of the Pictures in the possession of the Society of Antiquaries at Somerset House* (London, 1865), 42.
[263] Charlett to Wanley, 9th May, 1720, cit. J. Ingamells, *Later Stuart Portraits*, *1685-1714* (London, 2010), 314.
[264] DNB.
[265] This matter is in the 'Welbeck Wanleyana', a collection of letters, receipts and other paraphernalia now found in BL Add. MSS 70481.

Wanley was rather taken with Hill's final rendition. He commented humbly to Harley that "mine will soon be finished, so as to furnish-out a good Performance upon a very mean Subject".[267] He also commented to Schumacher that

> Mine goe's on bravely, and will be his [Hill's] Master-piece. I am represented therein as holding a fine Brass-Head of the Emperor Hadrian, bigger than the Life, & of Grecian workmanship, which....[has] come in, since you went from hence.[268]

In the final piece, finished in mid-June 1722, Wanley's left hand rests on his knee, while his right is propped on the bust of Hadrian. The skin of his face appears rougher in some places than in others, an appearance accentuated by the light beaming onto the right eye socket and forehead.[269] There, just to the left of his lips, is the dramatically white pockmark standing out on Wanley's left cheek. None of Wanley's comments about the portrait permit us confidently to claim that the marks are a conscious representation of smallpox scars, save perhaps his modest reference to his own meanness (and he was no mean critic).[270] If anything, his comments would have us believe that the portrait was painted to let Schumacher know what antiquities Wanley had recently purchased. It is left to the effects of light and the contrast of tone – the very mechanics of artistic representation – to make any suggestion of smallpox scarring.

Bearing this in mind, and recalling the readings of the earlier two portraits, it seems that the appearance of indentations on the skin that would denote pockmarking were made

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[266] Wanley to Edward Harley, 8th May, 1722; in *Letters of Humfrey Wanley, Palaeographer, Anglo-Saxonist, Librarian, 1672-1726* (ed. P. L. Heyworth, Oxford, 1989), 443.

[267] Wanley to Ed. Harley, 8th May, 1722; *Letters of Humfrey Wanley*, 443.

[268] Wanley to Johann Schumacher, 26th May, 1722, *Letters of Humfrey Wanley*, 444-5. Cf. same to same, 31st May, 1722; *ibid.*, 445.

[269] The light also catches both hands. The connection between the head and the hands – for a scholar as for any supposedly educated man – girded contemporary definitions of creativity and intelligence. See Wedgwood's example below, and also chap. II.

[270] For Wanley's aesthetic appreciation, see *Diary of Humfrey Wanley*, i, 48; i, 62-3; i, 71; ii, 329; ii, 357. He also read a paper on the history of art to the Royal Society in December 1703: see *Philosophical Transactions*, XXIII, no. 288 (1704), 1507-16.

far more visible in the portrait that was not just about Wanley the man, but in which his work was equally the subject to be captured. Whereas the 1711 portrait even made the pockmarking part of the representational scheme of the painting, the later portraits appear to depict the pockmarks only as a matter of *appearance*. This is to suggest that the pictorial logic of the earliest portrait ushers the viewer towards an analysis of the portrait that must take Wanley's smallpox into account. There is a paradox here. In making the illness more visible in the painting, Hill actually casts it as a *background* theme in order to draw attention to something else: Wanley's work. Because the portrait stands for something more complicated than an emblem of the man, the signs of his illness are *both* a literal depiction and a pictorial device. All in all, the representation of Wanley's scarring had different implications depending on the origin and circumstances of his portraiture.

William Hazlitt

Wanley's case-study shows how important probing the overall aesthetic logic of portraiture is. Analysing this necessarily brings the role of the artist to the fore. Famous essayist William Hazlitt's (1778-1830) own portrait of his father, painted in 1802, does likewise (Figure 19). The canvas, now in Maidstone, is so heavily cracked that Hazlitt senior's likeness is barely visible. One can just about make out a bespectacled old man bathed in a warm red light, which shines onto the left side of his face. No evidence of pockmarking is immediately evident from this greatly interrupted view – and the cracks would preclude definitive descriptions of such details in any case. However, the younger Hazlitt's own touching account of the portrait's production in his essay 'On the Pleasures of Painting' referred quite plainly to the smallpox and how he rendered it:

> One of my first attempts [at painting] was a picture of my father, who was then in a green old age [68], with strong-marked features, and scarred with the smallpox. I drew it out with

> a broad light crossing the face, looking down...reading. [...] The sketch promised well, and I set to work to finish it, determined to spare no time nor paint. My father was willing to sit for as long as I pleased; for there is a natural desire in the mind of a man to sit for one's picture, to be the object of continued attention, to have one's likeness multiplied. [...] When I gave the effect I intended to any part of the picture for which I had prepared my colours; when I imitated the roughness of the skin by a lucky stroke of the pencil; when I hit the clear pearly stroke of a vein; when I gave the ruddy complexion of health, the blood circulating under the broad structures of one side of the face, I thought my fortune made.[271]

Hazlitt begins with a frank but warm assessment of his father's appearance. It combines the poetic with the blunt and matter-of-fact. He plays on the oxymoronic "green old age", as though age has not altered the son's view of his father. We also notice that Hazlitt singles out his father's smallpox scarring from his other "strong-marked features". The smallpox's effect on his father's appearance was the most striking feature of the son's view of the old man. The damage to the canvas makes it simply impossible to tally Hazlitt's view of his father with the portrait. Yet Hazlitt does mention the joy he derived from imitating "the roughness of his father's skin by a lucky stroke of his pencil". This simple phrase seems to suggest that Hazlitt revelled in depicting what he thought was a fundamental aspect of his father's identity at the time. He saw nothing negative in representing it.

This interaction will have been partly governed by the dynamics of their father-son relationship as well as by the routine conditions of sitting "for as long as I pleased". Relatively little attention has been paid to the psychic or social dynamics of portraying direct relatives.[272] It would appear that Hazlitt's joy in portraying the stark realities of his father's likeness – scars and all – was a part of his filial devotion. This portrait was just another "multiplier" of a glowing likeness that had been in the son's eye for some time.

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[271] W. Hazlitt, 'On the Pleasure of Painting', in *idem*, *Table Talk: or original essays* (London, 1821), 1-21, at 19ff.
[272] For a modern-day example, cf. Daphne Todd, *Last Portrait of Mother* (2009).

Indeed, the portrait confirmed Hazlitt senior as an "object of continued attention". For the Hazlitts, painting the father's rough scarred skin was a way of commemorating, even romanticising and valorising, a specific son's-eye view of a man. Depicting the tropes of illness therefore had a direct social function. For Hazlitt junior, the impression would have been balder and devoid of sentiment had he not painted his father's scars.

Josiah Wedgwood

My final case-study concerns the master-potter, Josiah Wedgwood (1730-1795). It ties together a number of the threads of analysis spun through the previous examples. It concerns a portrait that did not move around or change hands or reincarnate into many derivative prints. It remained in Wedgwood's family, viewable only to those who were granted access to it. In order to test the nature of the artist's influence on the look of smallpox portraiture, we can compare two coterminous portrait transactions between Wedgwood and the same portraitist. Indeed, Wedgwood's portraiture demonstrates how a portrait's intended setting and the artist's circumstances influenced the production, the representation and the viewing of the signs of illness. Wedgwood's case therefore provides a bridge to the second part of the chapter, which focuses precisely on viewing.

Wedgwood contracted smallpox during his apprenticeship in around 1741, just before he was twelve. Although he survived the disease, which went confluent, it weakened him so greatly that he caught a secondary infection – Brodie's abcess – in his right knee.[273] This knee became permanently disabled to the point where his leg had to be amputated in May 1768.[274] The illness affected his potting practice. Both before and after the amputation, Wedgwood had to use a special machine during his stints at the potting wheel.

[273] E. Meteyard, *The Life of Josiah Wedgwood...* (London, 2 vols.., 1865), i, 220.
[274] Cf. Meteyard, *Life of Josiah Wedgwood*, i, 246.

Wedgwood's portraiture is extensive and varied. He was the subject of at least nine different likenesses, which were taken over a period of approximately thirty years. His iconography includes painted oils, an enamel, a marble sculpture, a miniature statuette, jasper medallions (after his own factory's designs), and various engravings. Only two artists, George Stubbs and William Hackwood – the latter being Josiah's assistant at his Etruria factory – portrayed Wedgwood more than once.

David Shuttleton was of the opinion that the only portrait to divulge anything of Wedgwood's smallpox was Hackwood's second ceramic relief medallion struck in 1782. Shuttleton inferred pockmarking from the small rough marks on the left cheek bone. (The medal is a left profile.) Yet there is little evidence from the records of firing that there was anything untoward about this medal; and it is prudent not to rule out the possibility of natural flaws in the jasper, which might also go some way to explaining the roughness near the bottom of the same medallion, below the third button-hole of Josiah's coat.[275] Additionally and crucially, even if his inference holds, Shuttleton did not explain why this portrait was so unique.

Indeed, two other portraits suggest signs of smallpox. The first is Joshua Reynolds' 1782 likeness. However, for want of evidence, it is difficult to pursue the differences between how the originals and replica copies of this portrait presented Wedgwood's scarring. The other portrait of Wedgwood that indicates scarring is George Stubbs' portrait of Wedgwood and his family (Figure 20). What about this portrait sets it apart from the others, and why should this be? What can it tell us about the representation of signs of illness and the response to it? In answering these questions, it is important not to wrench the analysis away from what the portrait itself invites us to consider. I shall explain how the representation of the signs of illness could be situated within the parameters of other concerns, such as the production of an icon of family power and prestige.

[275] I am grateful to Mrs Lynn Miller at the Wedgwood Museum for discussing these matters with me.

The portrait was conceived – and the transaction undertaken – as part of a practical business deal that Wedgwood and Stubbs struck in the late 1770s. Stubbs was looking to experiment with enamel paintings, and wanted extra-large thin ceramic tablets that did not require extra copper supports.[276] He turned to Wedgwood. Wedgwood tried and tried but could not make them. Since the manufacturing cost was racking up, Stubbs asked whether Wedgwood would accept paintings as part-payment-in-kind for the tablets.[277] Wedgwood agreed, and Stubbs duly went up to Etruria Hall in the summer of 1780. Stubbs offered to paint Josiah and his wife, Sarah, using two of the enamel plates that Josiah had fabricated but that Stubbs did not want for himself. Besides these portraits, the two men discussed family portraits. Josiah favoured two portraits, one of his daughters and one of his sons. But Stubbs preferred one large whole-family portrait. Stubbs prevailed.

The production of the portrait is discussed in letters that Josiah wrote to his great friend, business partner and London agent, Thomas Bentley. The portrait was painted over the course of four months, from August to November 1780. Wedgwood sat several times to Stubbs during that time. He and Stubbs shared the production space: Josiah was using a stable as an office while Etruria Hall was being redecorated; he gave half of it over to Stubbs as a studio. This already suggests that Wedgwood could scrutinise the portrait closely as it was being made. Perhaps this implies collaboration, too, with Josiah glancing over Stubbs' shoulder every now and then and making comments. Josiah was himself a craftsman with a keen eye for design and manufacture. We know that he allowed his own clients to dictate the very look of some of the "classes" of wares that his factory produced: notwithstanding any promotional sycophancy, Wedgwood claimed his products were "so

[276] A full run-down is found in J. Egerton, *George Stubbs, painter: catalogue raisonné* (New Haven and London, 2007), 433ff; with it, cf. R. Vincent-Kemp, *George Stubbs and the Wedgwood Connection* (Stoke-on-Trent, 1986), 27; and for more context, see B. Tattershall, *Stubbs and Wedgwood: unique alliance between artist and potter* (London, 1974).

[277] Wedgwood to Bentley, 30th May, 1799; www.wedgwoodmuseum.org.uk/collections/online/object/3459; accessed 16th January, 2012.

frequently varied to suit the tastes of those who honour me with commissions for them".[278] Moreover, letters bear out that Wedgwood had friends over to check the progress of the picture, too (see below). All this might make us infer a pressure on Stubbs equal to Josiah's level of interest, although Josiah did not leave explicit views on the level of authority and freedom a master craftsman (such as both he and Stubbs were) should be afforded.

It was Stubbs' usual practice to make detailed preparatory sketches.[279] Sketches were certainly made of Wedgwood and his family because Josiah commented that his painted likeness did not match his sketch. (These sketches are not extant.) Wedgwood was quite precise in his demands because he reported to Bentley that he wanted Stubbs to "give any last touches which may be found wanting" in order to bring the finished oil up to the standard of the original sketches.[280] This tells us that Wedgwood was indeed rather fastidious about the overall look he expected the portrait to show. In fact, he was rather critical of the portrait generally speaking. Wrote Wedgwood on 14th September, 1780:

> I think the likenesses promise to be strong, but...the likeness in those that approach towards being finished grow weaker as the painting increases. Mr Stubs [*sic*] says the likeness will come in and go off many times...so I can say nothing, only that the first sketches were very strong and the after touches have made them less so.[281]

Stubbs clearly reassured Wedgwood that his appearance was not static, but rather quite mutable, during the physical acts of painting. This implies that permanent features – including presumably pockmarks – could come and go as the portrait progressed.

The completed painting is a large portrait that shows Josiah and Sarah sitting on a tree bench. Their younger children are playing. The elder children are saddled on horseback. The most immediately engaging features of the painting are its enormous scale

[278] J. Wedgwood, *Catalogue of Cameos, Intaglios, Medals, Bas-reliefs, busts...* (London, 1773), 3.
[279] See Egerton, *Stubbs*, 429.
[280] Wedgwood to Bentley, 14th September, 1780, *Selected Letters of Josiah Wedgwood*, 257-8.
[281] Wedgwood to Bentley, 14th September, 1780; *Selected Letters of Josiah Wedgwood*, 257-8.

(fully two panels' worth), the fact that it is staged outdoors, the horses, the vase (one of the factory's 'first-day' vases), Josiah's awkward stance, and – when one peers closer – the treatment of the faces. These details invite various levels of analysis.

The first is to take the painting as a 'paterfamilias' painting. Josiah is portrayed as the head of a blossoming family. His children are all engaged in pursuits that befit their age and roles within the family. He lets his children play. He has clearly taught his elder children the socially advantageous skill of riding. His sons wear similar hats to their father, as though they are biding their time before emulating him. Indeed, the children occupy the centre-ground – none more so than the eldest daughter, who is portrayed dashingly and elegantly, perhaps on view to potential suitors. Meanwhile, Sarah is cast as an attentive mother, gesturing to the youngest daughter. The portrait is set in the grounds of Etruria Hall and includes a vista that gives onto the Etruria factory itself: the portrait alludes forcibly to Wedgwood's landed and economic power. As a member of the gentry who has acquired wealth by aggressive commercial artisanship – itself suggested by how the fingers clutch the designer's pencil – Josiah's portrait might well be a nod to the aristocratic tradition of being portrayed in the rolling acres of one's country seat.[282] In many respects, the portrait is a scene typical of eighteenth-century family outdoor portraiture and sits well in the traditions of Devis and Mercier and latterly Zoffany and Gainsborough. Wedgwood was not oblivious to the role that iconography could play in a family's ostentatious displays of power. His factory produced armorial wares (basically crockery with family crests, heralds and motifs emblazoned all over them). The Bedford set on display at the Wedgwood Museum in Barlaston is one example (Figure 21).

The second level of analysis centres on Stubbs' interests in painting the portrait. He clearly asserted his interests: we recall he got his own way in painting one large family piece

[282] Josiah commented that because of the problems with his eyes (see below), he came to "see with his fingers": cit. F. A. Jonsson, 'Enlightened Hands: Managing Dexterity in British Medicine and Manufactures, 1760-1800', in C. E. Forth and I. D. Crozier (eds.), *Body parts: critical explorations in corporeality* (London, 2005), 142-60, at 151ff.

instead of two portraits of the children. The Wedgwood family portrait would have been a perfect advert for Stubbs. Stubbs had become famous for painting animals, especially horses. He published a lavishly (and personally) illustrated text book on the *Anatomy of the Horse* (1766) and had won many prestigious racehorse and 'sporting art' commissions.[283] He had become rather typecast as an animal painter; he told Wedgwood that he desired to be known as a portraitist and History painter as well as a painter of animals.[284] To that end, he networked throughout the Potteries and the west Midlands during his time with Wedgwood and earned at least two other portrait commissions on the strength of his Wedgwood connection. A portrait like Wedgwood's, of mounted gentry, to be displayed to Josiah's friends, would be a potent signal of Stubbs' dual abilities and career aspirations.

Other levels of analysis draw us closer to Josiah's illness and to the representations of the sitters themselves. Josiah's pose is decidedly awkward; he sits leaning to the left in an un-relaxed pose. The heel of his right shoe seems to hang on the ground. The exaggerated right-angle of the right leg contrasts sharply with the extended left leg (a leg-pose certainly more in keeping with eighteenth-century trends).[285] The right shoe is not flat to the ground. No forward pressure is exerted. Josiah's weight is transferred to the left. His leaning on the table and his manner of holding his pencil partly disguises the fact that there is a mismatch between the angle of his legs and his torso. The leaning is a necessary pose. Stubbs portrayed Wedgwood in a posture demanded by the wooden leg that Josiah had to wear following his amputation at the knee. If these observations are valid, they overturn P. J. Bemrose's claim that the false limb "does not show up in the portraits and statues of [Wedgwood]".[286]

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[283] See e.g. A. Cunningham, *The Anatomist Anatomis'd: An Experimental Discipline in Enlightenment Europe* (Farnham and Burlington, 2010), 342ff; S. Deuchar, *Sporting Art in Eighteenth Century England: A Social and Political History* (New Haven, 1988).

[284] Wedgwood to Bentley, 25th September, 1780, *Selected Letters of Josiah Wedgwood*, 258-9.

[285] E.g. Thomas Gainsborough, *Portrait of the Artist with his Wife and Daughter* (1748) and Arthur Devis, *Peter Ducane* (1747).

[286] NPG Heinz Archive: sitter box – Wedgwood.

Josiah's face betrays that Stubbs paid further attention to the signs of the disease. Josiah's face is treated very roughly, almost blotchily. (It is arguable that Sarah's face is no less blotched. I have not been able to ascertain whether she, too, suffered smallpox.) Nevertheless, the painted light bounces off Josiah's face with such varying intensity that it emphasises the contours of the scarring in a way that is unapparent on Sarah's face (cf. Wanley's case above). We are then invited to compare the complexions of the adults with the children, who are mostly soft-skinned, rosy cheeked, or (in the case of the eldest daughter) tinted, perhaps by make-up (Figure 22).

Overall, this portrait is a study in surfaces and texture. Josiah is painted with rough skin in a medium (board) that deadens a glossy substance (oil paint) as it absorbs and dries. He is painted, indeed, by someone at a career crossroads experimenting with different materials (the very *raison d'être* of the portrait). We have seen already how a pockmarked face was likened to all sorts of artisanal craftsman's materials: hard and crusty enamel, dull leather, parchment, and also the naturally rough exterior of wood. The portrait was painted for one whose livelihood depended on knowledge and awareness of different materials – a livelihood specifically commemorated by the setting and the inclusion of the first day vase.[287] Indeed, it was painted for one who made and worked with smooth porcelain, the epitome of smoothness and a strong metaphor for both fragility and the smoothness of skin.[288] The choice of medium therefore ought not to pass unnoticed. Large canvases were undoubtedly available in this period – witness J. S. Copley's gigantic *Death of Chatham*, for instance – so a choice was made to opt for board.[289] The very choice of Stubbs' medium will have increased the possibility of rendering Josiah's pockmarks more visible, even before a dab of paint was actually applied.

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[287] For Wedgwood's (professed) knowledge of materials, see Wedgwood, *Catalogue of Cameos...*, 2ff.

[288] See, e.g., J. Robertson, 'Eve's Legacy to her Daughters', in *idem*, *Poems of Several Occasions* (London, 1773), 92.

[289] For more on the availability of canvases, see Jacob Simon's invaluable online register of artists' suppliers: www.npg.org.uk/research/programmes/directory-of-suppliers. I am grateful to Dr Simon for his advice on this point.

Then we look into Josiah's eyes. The left eye appears to squint or droop markedly – in fact almost drawing the viewer's eyes down onto his rough cheek. Representing signs like these was not a straightforward decision. Whether to represent eye conditions, for instance, was not a clear-cut matter. Certain sitters like Joshua Reynolds, John Wilkes and John Fielding were happy to lay their eye deficiencies bare and even to exploit them for artistic purposes.[290] On the other hand, Samuel Johnson once roared to Hester Piozzi that he refused point-blank to be painted for posterity as "*blinking Sam*".[291] As far as smallpox victims are concerned, they erred on the former side, preferring to use the defect to make a point about the illness. Thus Thomas Blacklock, for instance, who wrote a farcical poem called 'The Author's Picture' from the standpoint of a blind self-portraitist and who accompanied it with his portrait as a blind man by William Bonner.[292]

These initial readings of Josiah's complexion and eyes gain weight as we bear in mind both his own comments about the likeness and Stubbs' comments about the way he painted. Intriguingly, Stubbs reported to Wedgwood that he preferred to "copy nature" than paint in ideal form to a client's order.[293] This tallies with Stubbs' friend, Ozias Humphry's judgement that Stubbs "proceeded unassisted to make all his studies after nature, intending by every thing he did, to qualify himself for painting...portraiture".[294] Wedgwood, unhappy at the progress of the likenesses from sketchbook to board, thought that "some parts [of his likeness] are a little caricatured, or mine own eyes and those of many of my friends are much deceived."[295] What was Stubbs' portrait showing? What could Josiah and his friends see? It is entirely plausible, as we shall see in the next chapter, that the aspects of Josiah's likeness that aligned with contemporary notions of caricature were those that emphasised the signs of illness: his wonky eye, artificial limb and gnarled face.

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290 On Wilkes, cf. chap. II below.
291 Cit. P. Smallwood, *Johnson's critical presence: image, history, judgement* (Basingstoke, 2004), 106.
292 Shuttleton, *Smallpox and the Literary Imagination*, 152ff., esp. 154.
293 Wedgwood to Bentley, 13th August, 1780; *Selected Letters of Josiah Wedgwood*, 254.
294 Cit. Cunningham, *The Anatomist Anatomis'd*, 344.
295 Wedgwood to Bentley, 21st October, 1780, *Selected Letters of Josiah Wedgwood*, 260.

Another comment suggests that Josiah knew that his scars and his wooden leg had been rather openly painted. Despite his reservations about the portrait, Josiah did not command Stubbs to remove the unsatisfactory depictions – which, by the sounds of his earlier comment about matching the sketches, he could have done had he wanted to. In his letter to Bentley of the 21st October, 1780, Wedgwood noted that:

> He [Stubbs] certainly has not observed Mrs Montague's maxim respecting her model, but I will not say any more upon this subject at present, *and this is only to your self*.[296]

To whose "model" is Wedgwood comparing himself, here? There are, I think, two possibilities. On the one hand, he could be referring to Lady Mary Wortley Montagu. If this is the case, he might well have had in mind Montagu's (fictional) model Flavia, whom Montagu, in her poem 'Saturday: The Small Pox', casts as bemoaning her pockmarks and rueing her lost beauty. No explicit "maxim" in this poem refers to portraiture, however. Wedgwood might also have had in mind Montagu's own portraiture, in which case her "model" would simply stand for her own figure. Montagu did not allow her portraits to show the symptoms of her smallpox, a fact which Marcia Pointon has suggested was part of her wider sexual re-presentation (see above).[297] The other possible "Montague" that Wedgwood may have been referring to is Lady Elizabeth Montagu, the bluestocking.[298] This might be the more plausible suggestion, if only because she was Wedgwood's contemporary and because Wedgwood made a jasper medallion 'model' of her as part of his neo-classical "Heads of Illustrious Moderns" series (Figure 23).[299] This latter is a sleek veiled likeness that contemporaries identified with Minerva and virtue.[300] Might Montagu have delivered Wedgwood himself a maxim that his portrait of her embodies, in all its

[296] Wedgwood to Bentley, 21st October, 1780, *Selected Letters of Josiah Wedgwood*, 260.
[297] Pointon, 'Killing Pictures'.
[298] See E. Eger, *Bluestockings: Women of Reason from Enlightenment to Romanticism* (Basingstoke and New York, 2010); and E. Eger and L. Peltz, *Brilliant Women: 18th Century Bluestockings* (London, 2008).
[299] Eger and Peltz, *Brilliant Women*, 65; Eger, *Bluestockings*, 63; Wedgwood, *Catalogue of Cameos...*, 54.
[300] Cf. Samuel Johnson's 'On Seeing a Portrait of Mrs Montagu', cit. Eger and Peltz, *Brilliant Women*, 66.

highly polished, porcelain-white smoothness? Evidence is little forthcoming on this question. Wedgwood's familiarity with Lady Mary's portraiture – and her poetry for that matter – is unsubstantial; so is Bentley's. As for Lady Elizabeth, Wedgwood did not correspond with her directly, and there is nothing about the manufacturing processes of her medallion that Wedgwood singled out for special mention.

Josiah's comment to Bentley warrants one final remark – on secrecy. Wedgwood insisted that he wrote about his portraits in confidence. Wedgwood did not want his critical comments, including his comparison with "Mrs. Montague's... model", to be circulated. Wedgwood did not want anyone else but his trusted friend to know of how he thought the portrait looked. Was he worried that others would spot these signs? The word 'maxim' is also quite significant, since it suggests some set of rules governing the look of 'models'. Wedgwood was clearly thinking about the how the conventions of portraits related the idiosyncrasies of his likeness: the signs of his illness. Yet however worried he was about word spreading, he was not dissatisfied enough to force Stubbs to efface the signs of his suffering.

Why did Wedgwood not mind Stubbs' painting him in this way – why did he let him get on (or away) with it? Our analysis can be strengthened by returning to the point made about surfaces and comparing the other portrait of Wedgwood that was made at precisely the same time, during Stubbs' same visit to Etruria. This second portrait, painted on enamel, was also made to pay Wedgwood – so there is no peculiar context (Figure 24). Fired and glazed enamel is inherently a far glossier medium than oil on board.[301] Yet the differences in representation are also stark. Crucially, Stubbs' enamel portrait of Josiah bears no sign at all of matt, pockmarked skin. Indeed, he cast the skin as fulgent, almost glowing. Nor does it show a defective eye (although there is a slight technical glitch in their focus). Finally, being a half-length only, it eschews the problematic leg.

[301] We know, however, that this portrait apparently bubbled and cracked a little on firing; Egerton, *Stubbs*, 430.

Besides the immediate differences of appearance, another crucial fundamental difference between these portraits consists in their intended settings. The enamel portrait was among those publicised and made available for reproduction. Indeed, it was copiously reproduced – most obviously on the occasion of Josiah's death in 1795.[302] Enamel itself betokened complimentary traits of refinement and sensibility, both important for a public likeness.[303] The family portrait, by contrast, was intended to hang – and was indeed hung – in Etruria Hall, the Wedgwood home. Privacy was not, as we have seen, a reason for the painting existing in the first place, but it well accounts for Josiah's acquiescence in Stubbs' stylistic choices and supposedly inferior likenesses. Although friends and associates would pass through the family villa, it was by no means a setting where anybody could observe (and extrapolate from) the visible relics of his illness. Indeed, as Wedgwood intimated in his letter to Bentley, he could control access to this likeness – control in what circumstances people saw him in this state.

Portraits, especially family ones, were a crucial part of the domestic interior. Their arrangement was carefully controlled throughout the early-modern period.[304] They were, as mentioned earlier, important projectors of family power as well as personal interests. Stubbs' family portrait is unique among Wedgwood's portraiture for depicting the legacy of his smallpox. Yet it is also unique for being the only one to include members of his family and expressly to be hung in a private domestic setting. The point here is that the final intended setting of the portrait – if it was, unlike the artist's precise rendering, within the absolute control of the sitter – permitted a more extensive representation of the signs of illness. This builds on the point made for Wanley's example. The focus and destination of a portrait are crucial determinants of the decision making behind a portrait. They bear directly on whether the signs of illness were deemed appropriate to paint.

[302]NPG Heinz Archive: sitter box – Wedgwood.
[303] Nussbaum, *Limits of the Human*, 3.
[304] The starting place for family portraiture is Retford, *The Art of Domestic Life*.

Royalty

The second set of case-studies of this chapter deals with portraits of royals who were known to have suffered a particular ailment. The emphasis switches from the disease to the sufferer. Instead of examining portraits of people who suffered the same illness, I turn to portraits of the same type of person, whatever their illness(es). This will help us to consider whether diseases or sitters were more prominent in determining how a portrait showed illness. If sufferers of the same disease all dealt with the problem of portraying the same symptoms very differently, were similar people portrayed with different illnesses in similar ways?

Royals provide a good working example for a number of reasons. First of all, they are a tightly defined group within early modern society. Contemporary political arithmetic and biographical portrait anthologies bear this out.[305] Second, portraits and the dissemination of their image were keen concerns for early modern monarchs.[306] For instance, on a medical theme, the proliferation of prints of Charles II's touching for scrofula helped (re)cast the restored monarchy as divinely-ordained.[307] The third benefit is that royals tended to commission leading fashionable artists. This means there are often many other portraits with which we can compare royals' ones. Fourth, the peculiar station of royals meant that their portraits were particularly susceptible to convention, pomp, stylisation and homogeneity, even if they did also reflect changing social circumstances (such as changing family structures).[308] Choosing to depict the signs of illness would

[305] For exemplary starting points, see Gregory King's 1696 estimates, and (for portraits) Thomas Birch's *Heads of Illustrious Persons of Great Britain* (London, 1742-56).
[306] On British monarchs, see e.g., R. C. Strong, *Gloriana: The portraits of Queen Elizabeth I* (London, 1987); K. Sharpe, *Image Wars: promoting kings and commonwealths in England, 1603-1660* (New Haven and London, 2010); for the impact of the Commonwealth on personal portraiture, see L. L. Knoppers, *Constructing Cromwell: ceremony, portrait, print, 1645-1661* (Cambridge, 2000).
[307] See S. Brogan, 'The Royal Touch in Early Modern England: Its Changing Rationale and Practice', Uni. of London Ph.D. thesis, 2011.
[308] See S. Schama, 'The Domestication of Majesty: Royal Family Portraiture, 1500-1800' *Journal of Interdisciplinary History*, 17, 1 (1986), 155-183, and, more generally, Retford, *The Art of Domestic Life*.

involve resisting some of these stylising pressures. Fifth, monarchs' health (and its perception) had important ramifications for political and national life. Queen Anne's collapse from health in the 1710s dashed the fortunes of the tory party.[309] A century later, George III's continual health problems fuelled arguments for and eventually led to regency (see below). Sixth, monarchs' health was more widely and persistently discussed than that of any other single group in our period – except perhaps when concerns for public health, sanitation and nutrition among the urban poor gained momentum in the nineteenth century.[310] The ability of portraiture to portray a healthy monarchy was activated by this increased concern..

The trend for glossing

The majority of royals' portraits of the long eighteenth century gloss over any illness whose outward signs might have been depicted. Smallpox illustrates this point nicely. Queen Anne was known to have suffered a bout of smallpox in 1677. Her entire iconography comes after this and *could* have shown some scarring. Yet there is very little evidence of pockmarking on any of her portraits (see Figure 25). Anne's husband, George of Denmark, was likewise known – to Sir Thomas Clarges for one – as a man "very comely, [with] faire hair, [and with a] few pock holes in his visage". But his iconography is likewise pock-free.[311] So is George II's.[312]

Others' iconographies are also blemish-free. William, Duke of Gloucester suffered from hydrocephalus, but his head was not shown at all disproportionately large. George III's wife, Queen Charlotte, was reputedly upset by an unflattering and informal portrayal

[309] See the family tree compiled by John Empson in *Journal of the Royal Society of Medicine*, November, 1996, 660 and the comments by Milo Keynes in *Journal of the Royal Society of Medicine*, January, 1997, 60.
[310] George II's autopsied heart was even drawn and engraved for the readers of the *Gentleman's Magazine* in 1760. Cit. L. Worsley, 'Fit to Rule: How Royal Illness Changed History', episode 2 of a BBC2 television series broadcast in April, 2013.
[311] Cit. Ingamells, *Later Stuart Portraits*, 93.
[312] Cf. J. van der Kiste, *George II and Queen Caroline* (Stroud, 1997), 21.

by Sir Thomas Lawrence, which coincided with the stress of her husband's illness (see below); yet she approved of the final likeness when it was displayed in the 1790 Royal Academy exhibition.[313] It is fair to say that most royal portraitists depicted their sitters as majestic and healthy.

However, there is at least one striking exception to this rule. The remainder of this section considers portraits of George III. His portraits reveal that artists found ways of moulding the genre of portraiture precisely to show a royal's illness. This again advances the point that showing was dependent upon the specific circumstances of the sitter and his portraits.

George III

George III (1738-1820) is perhaps the most famous ill royal in British history. I wish to make three points about George's portraiture. First, showing his illness was not out-of-bounds. Second, his portraits could (in different ways) be 'about' him *as* a sufferer or a patient. Third, conventions of royal portraiture were adapted to suit the realities of portraying an ill king. His illness and status may have restricted his portraiture in certain ways, but it did not preclude showing him as an ill man.

George III was periodically of unsound mind. His modern-day diagnosticians, mother-and-son-duo Ida Macalpine and John Hunter, diagnosed porphyria, although that particular diagnosis is increasingly disputed.[314] George first suffered from mental instability in the 1780s, again in the early 1800s, and then finally from 1810 onward with no let-up. Indeed, from 1810, no positive prognoses issued from the panel of physicians reporting on him. Wary of the constitutional stresses of the 1780s, parliament in 1810 deemed George

[313] M. Levey, *Sir Thomas Lawrence* (New Haven and London, 2005), 85ff.
[314] See, for instance, T. Peters, 'The Madness of King George III: A Re-examination of the Records', http://www.rcpe.ac.uk/streamingdemo/EHMG_Peters120308/launch.html; accessed 20th April, 2012. (Peters' computer-reliant methodology is based on modern-day categories.)

unfit to wield royal authority. By the power of the Care of the King During His Illness Act 1811, George's powers passed to his son as Prince Regent. The king himself was entrusted to the care of his wife. From that point, George never recovered but gradually declined. Physicians were still retained to look after him and report on him – as immortalised in *The Madness of King George* or in Michel Foucault's interpretation in *Psychiatric Power* (in which Foucault describes a royal role reversal between the king and his chief physician, John Willis).[315]

Treatment was to no avail. The old man grew wizened and frail. Although physically confined, there was intense public interest in his health. Regular health reports – versions of the doctors' reports – were circulated in the national press. They provided heavily mediated evidence of his appearance during these years. *The Times* for the 28th September, 1818, for instance, narrated that "His Majesty is perfectly blind...The King suffers his beard to grow two or three days, seldom, however, exceeding three days. His hair is perfectly white."

Portraits of George are numerous (and satires even more plentiful).[316] They encompass magnificent state portraits like Allen Ramsay's (Figure 26), military full-lengths like William Beechey's (Figure 27), family portraits like Johan Zoffany's, busts like Peter Turnerelli's, hundreds of engravings in various methods, right down to everyday '*ex officio*' items like coins. The list of his portrait artists reads like a *Who Was Who* of fashionable and important painters of his reign. How does his extensive iconography relate to his illness? Scanning his whole iconography, no portraits were made of George during the first two bouts of his illness – i.e. *as* he was suffering. Rather, in this period, imagery that concerned George's health tended to relate to his recovery: for instance, *On the General Illumination of*

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315 M. Foucault, *Psychiatric Power: Lectures at the College de France, 1973-74* (trans. G. Burchell, Basingstoke, 2006), 20ff.

316 The best starting point for satires of George III remains F. G. Stephens and M. D. George, *Catalogue of Political and Personal Satires preserved in the Department of Prints and Drawings in the British Museum* (London, 11 vols.., 1952), but see also V. Carretta, *George III and the satirists from Hogarth to Byron* (Athens, GA, 2008) and D. Donald, *The Age of Caricature: Satirical Prints in the Reign of George III* (New haven and London, 2008).

His Majesty's recovery (Figure 28), or *The Triumph of Hygeia* (Figure 29); a medal was also struck to mark his return to health in 1789.[317]

Yet portraits *were* made of George during his last bout of illness in the 1810s. Of course, they constitute a minority of his portraits, but they all point with varying degrees of explicitness to the fact that George was an ill patient. Whereas certain portraits merely point out that George was portrayed "during his illness" – leaving the viewer to infer from the portrait how the king was suffering – other portraits provide more clues about his appearance during his illness.[318]

Samuel Reynolds' mezzotint-and-etched engraving shows an elderly George in three-quarter length, seated, wearing an ermine-trimmed gown, resting his head on his right hand, showing the onlooker a left profile (Figure 30).[319] Light is cast onto George's bald head and onto his left hand, which dangles over the arm of his chair with a very loose grip. Inscriptions on various derivatives of the print suggest that the sketch was taken from the life but not without restriction. The inscription reads that "this portrait was taken...from a slight view he [Reynolds] had of the king." It is not clear under what circumstances Reynolds had an audience with the king, but it does seem at odds with John Ingamells' suggestion that every likeness after 1805 "must have been derivative".[320] (Indeed, exactly the same phrase as used by Reynolds appears on James Heath's 1809 line and stipple engraving after Matthew Coles Wyatt.[321] "Slight" here seems to refer to the amount of time afforded to the artist to observe the king.) It seems probable that Reynolds' likeness was taken around 1817, for Henry Meyer's reversed engraving after Reynolds comes with the tag "Engraved by Henry Meyer from an Original / taken from the Life in the Year 1817".[322]

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317 WL 27217i; J. Ingamells, *Mid Georgian Portraits, 1760-1790* (London, 2004), 201.
318 E.g. WL 11478i.
319 NPG D8067.
320 Ingamells, *Mid-Georgian Portraits*, 202.
321 NPG D18598.
322 NPG D10680.

Whatever the precise date, we do know for sure that Reynolds' image was doctored. On the verso, in pencil, Reynolds explained that Dominic Colnaghi, son of the print-seller to the Prince Regent, showed a first draft proof impression to the Regent himself (Figure 31). The Regent was "much struck at the good likeness, and said it might be published, but with his own hand marked out at the back of the head where there was too much hair (vide the pencil marks)". The Regent, then, was the driving-force behind the engraving of his late father. He communicated his wishes to the engraver via his personal print-seller. We cannot say that the Regent made his suggestions to make the likeness truer to life. But his interference does tell us that the Regent wanted a very precise impression to be conveyed of his late father. It was not one of a hirsute man sitting lamely in his chair. Indeed, the portrait was designed in such a way that it would go against the grain of the impressions of his father that correspondents and other contemporary engravings had publicised,[323] and would also conform to a (then growing tradition) of 'senior' masculinity (Figures 32 and 33).[324]

We can safely assume that Reynolds obliged the Regent's wishes. The authorised print was published with "His Majesty's most gracious permission" by Reynolds on February 24th, 1820, not a month after the death of the late king (Figure 34). It was billed as a print of the *Father of the People* and dedicated to the nation. It is significantly bigger than the draft, at 16" x 12". These dimensions suggest that the engraving was an ornament, not an illustration.[325] The final impression carried an intriguing caption, a paraphrase of Job 19:11. Printed in bold capital letters beneath the likeness, it nodded quite explicitly to the conditions George suffered: "WHEN THE EAR HEARD HIM, THEN IT BLESSED HIM; AND WHEN THE EYE SAW HIM, / IT GAVE WITNESS OF HIM..." As well as to make a point about George's caring and charity, this borrowing refers directly to the

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323 E.g. NPG D10680.

324 E.g. Sir T. Lawrence, *George Canning* (1826) and T. Phillips, *Sir Francis Leggatt Chantrey* (1818). Cf. Pointon, *Portrayal and the Search for Identity*, 95f.

325 One was sold as a single lot (102) at Reynolds' sale at Christie's on 28th-30th April, 1836. See A. Whitman, *Samuel William Reynolds* (London, 1903), 17f.

very loss of his faculties that defined George's final years. It prompts the onlooker to identify the print with those medical conditions. The viewer need not hunt for illness iconography. Moreover, by including an inscription that prompts the viewer to associate the portrait with suffering and knowingly gaze on an unwell man, it associates the viewer to the illness: it makes George a patient by making the illness an explicitly social matter.

Charles Turner's *George the Third When Blind* (1820) also spoke directly, but in another way, to George's patient-hood (Figure 35).[326] Turner's portrait is similar to Reynolds' inasmuch as George is portrayed three-quarter length, seated, in a gown and with full beard and inasmuch as variously sized copies were made. But there are marked differences. We note immediately, for instance, that the title refers explicitly to George's condition, unlike in Reynolds' print. There are also marked differences in how Turner's portrait came to be: it is a derivative representation. Turner's portrait also comes to us in a different form from Reynolds'. Whereas Reynolds was primarily a mezzotinter, Turner worked in various techniques. This portrait survives in mezzotint-stipple-etchings or line engravings. Line engravings are time-consuming and costly to produce. Notwithstanding his decline from good health, this was a quite prestigious portrait of George, not a cheap throw-away.

Turner's portrait depicts George quite explicitly as a weak old man. No attempt is made to conceal his frailties. His eyes are closed. He wears a dressing gown and head cap. His hand droops and splays lifelessly over the arm of the chair. Unlike in Reynolds' portrayal of George – or in Thomas Lawrence's compositionally similar portrait of Pope Pius VII, commissioned by the Prince Regent and finished only a year before Turner's portrait appeared – George has no grip left. The hand had a privileged place in mankind's anatomical identity. Along with the face, it was thought to be our most individuating feature. Anatomical scholarship (e.g. Charles Bell's treatise on 'The Hand') as well as artists (especially van Dyck and Rembrandt) paid peculiar attention to them. Allan Ramsay's

[326] A number of copies exist. See, among them, NPG D16056, NPG D8001 and WL 11557i.

intricate and sumptuous studies of George's hands – for his portrait as the Prince of Wales – indicate the level of artistic care that had been dedicated to this feature of George's body (Figure 36).[327] The variable treatment of George's hands becomes more salient in this light. That George still had life and grip in his hand in Reynolds' portrait was an assertion of defiant strength – he had not lost control of this personalising feature. That strength had all gone in Turner's portrait. His loss of grip and his hand's lifeless flop portrayed George's ultimate demise. Its centrality to the composition emphasises that this was a focal part of his suffering.

Another feature of Turner's portrait is its dedication. Importantly, this portrait was explicitly dedicated to Frederick, the Duke of York, George's younger son (he of nursery-rhyme fame). The Duke of York was charged with looking after the King in his final two years, after the death of Queen Charlotte. As the Regent explained in a letter to his brother:

> I do most highly approve, as you must already know...of your being the individual to have the care of the poor dear King's person; indeed, in my opinion, you are not only the fittest person from every natural qualification for such responsibility....[328]

Frederick took to the care of his father with enthusiasm and devotion. He assured his brother "of the zealous care with which I shall execute the duties imposed on me".[329] He kept his word. On Frederick's death, Rev. John Abiss preached that he was a flower that "may preserve its sweetness in its leaves, and the kind and benevolent actions of a man send forth a fragrance...that reaches the grateful objects of their care."[330] Another posthumous memoir recalled that:

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[327] B. Allen, 'The Age of Hogarth 1720-1760', in *The British Portrait 1660-1960* (Woodbridge, 1991), 128-83, at 171.

[328] The Regent to the Duke of York, 25th January, 1819, in *The Letters of George IV* (ed. A. A. Aspinall, Cambridge, 3 vols.., 1938), i, 266-8.

[329] The Duke of York to The Regent, 23rd January, 1819, in *Letters of George IV*, i, 265-6.

[330] J. Abiss, 'A Sermon preached in...St. Bartholomew the Great...upon occasion of the death of H. R. H. Frederick, the Duke of York...' (London, 1827), 3.

> His family affections were strong, and the public cannot have forgotten the pious tenderness with which he discharged the duty of watching the last days of his royal father, darkened as they were by corporeal blindness and mental incapacity. No pleasure, no business, was ever known to interrupt his regular visits to Windsor, where his unhappy parent could neither be grateful for, nor even sensible of, his unremitted attention.[331]

This portrait, then, is dedicated to George's carer – precisely the person who made George a patient. Turner's was not the only portrait to recognise the importance of the Duke of York as George's carer. A coloured aquatint and etching by Joseph Constantine Sadler, originally impressed in 1811 (i.e. towards the beginning of George's final bout of illness) was reissued in 1819 with a dedication to the Duke of York – precisely at the time when he assumed responsibility for his father (Figure 37).[332] This portrait was recycled in order to make it a portrait of George as a patient.

The conventions of royal portraiture were not entirely done away with during the years of his illness – but their relation to the king was reconfigured during his illness. This reconfiguration can tell us about the implications of showing the signs of George's illness, particularly the implications for kingship and monarchy. Certain portraits set off the accoutrements of monarchy with the weakened form of the body of the king.[333] Engravings that exploited the disparity between the gleam, solidarity and timelessness of the monarchy's symbolism and the tired, decidedly mortal, body of the monarch himself forced the viewer to confront the realities of George's bodily infirmity. The portraits' use of such tropes penetrated the breach between the fixed notion of the monarchy and its transitory fragile incumbent.

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[331] R. Huish, *Authentic Memoir of the late Frederick, Duke of York and Albany...* (London, 1827), 38.
[332] NPG D10995 (the reissue).
[333] NPG Heinz Archive: sitter box – George III (misc. C. 1810-17, negative B61/288). Various satires exploit this discrepancy, too.

The king's fragile body was also used to recast conventional functions of the king as head of state. From 1810 onward, the Regent's extravagant tastes superseded those of his more sober and frugal father. As Boyd Hilton has described, court life became characterised by "fêtes, mock battles, levees and parties".[334] George Dance's undated semi-satirical[335] pencil sketch invokes and harks to one of the king's primary social duties as head of state: to receive state guests at large banquets (Figure 38).[336] Yet it is a role which the king can barely perform in this particular drawing. The title of the sketch makes plain that Dance depicted George receiving the Duke of Wellington at a masked ball, when the king was in "a lunatic phase". Yet the king, instead of being dressed in royal finery and masked, wears only a shawl. He is wizened and hunched over. He sports a long goatee bear, while his hair, bald on top, flows luxuriantly down his back. His frame is undignified, his clothing shabby, and he is unable to perform his role properly. It is fitting that he should wear no mask at a masked ball: nothing conceals his haggard appearance.

Allegorical figures are another conventional feature of portraits of monarchs and high dignitaries that George's portraiture exploited and adapted to the facts of his illness. Over the course of the long eighteenth century, allegorical tropes shifted from being ornamental flourishes[337] to especially powerful conveyers of character, especially in funerary portraiture.[338] For George, they were commandeered to mark his decline from health. For instance, in a stipple by Anthony Cardon after a miniature by Chalon, George's likeness is framed above a small ornament resembling a Roman family shrine that depicts two figures grieving over the ailing body of a third figure. The inscription bears out their plea: "Blest Nation, whom the Royal Sage / Has govern'd more than half an age / That added Years

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[334] Hilton, *A Mad, Bad and Dangerous People?*, 33.

[335] Material on this image has proven elusive. I say semi-satirical because it suggests at once pathos and farce. It certainly goes against the grain of Dance's oeuvre. Dance was a refined pencil draughtsman and made his name depicting well-to-do men, including physicians.

[336] NPG Heinz Archive: sitter box – George III (private collection 52, no. 69, negative 950/53 (15a)).

[337] A prominent example would be Kneller's *John Churchill, 1st duke of Marlborough* (1706).

[338] For instance, a tidal wave of allegorical engravings issued from prime minister Spencer Perceval's highly prominent death in 1812: D. H. James, 'Remembering the forgotten prime minister: the commemoration and afterlife of Spencer Perceval', Uni. of London M.A. essay, 2010.

may still be given, / Is that Nation's Prayer to Heaven."[339] The whole portrait is an allegory of grief, pity and despair at the suffering of the king.

George III's portraiture suggests that royals could be and were depicted as ill in our period. Several people wielded influence to affect how George's portraits showed the signs of his senescence and mental and physical decline. Two features of his ill portraiture are particularly salient: the explicit referencing of his patient-hood and the explicit adaptation of portraiture to suit the sad realities of illness.

Summary

Comparing the portraits of smallpox sufferers and royals reveals crucially important general traits of the 'showing' process. Different sufferers responded to the task of presenting the signs of their illness very differently. The intended setting of a portrait was crucial to the extent to which signs were showed: signs were more likely to be shown if a portrait was not intended for general (public) observation. Signs were also more likely to be shown in portraits whose representational purpose was not just to capture a sitter's likeness: we recall Wanley was most pockmarked in the portrait whose context of production was most about Wanley's status as an antiquarian.

Comparisons reveal that text and image were blended in different ways in different portraits. The allusions to Job were markedly different in portraits of William Thompson and George III; that exemplar of suffering was not invoked in any 'standard' way. Indeed, certain tropes came to the fore only in certain circumstances: allegorical allusions only really appeared in portraits of George that referred to his health.

Comparisons also enabled us to see that, in many respects, the showing process anticipated the looking process. Artists and sitters – and therefore portraits – anticipated what sort of audience might/could view it, and represented the sitter accordingly. Artists

[339] NPG Heinz Archive: sitter box – George III.

and sitters took future audiences and their presumed seeing patterns directly into account. Individual portraits responded in various ways to generic traditions and assumed viewing habits – including, for instance, the expectation of seeing a frontispiece portrait of the author of a book. In the light of this, let us now turn to examine looking at ill portraits.

Looking at ill portraits

The final part of this chapter briefly focuses on viewers of ill portraits. Unfortunately, the patchy evidence has not allowed me to confine this discussion to portraits of smallpox victims and royals.[340] While they would have given the benefit of some 'control' or 'constant', the point is to try to gain insights into what it was about portraits that prompted viewers to remark on the ill health of the sitter. And in that regard, it matters not what the illness *was* – but rather what and how it was *seen to be*.

As I explained earlier, paintings aroused much commentary. This period saw a great increase in the traffic of portraiture and painting in general. People of all ranks became more knowledgeable about what they were looking at. Some, like connoisseurs, designed rhetorical strategies to make sure they would always know more. (Attempts to stratify ways of seeing were not unique to viewers of portrait art, as, for instance, Anne Secord's work on botanical pictures has shown; cf. chap. IV.)[341] But even outside learned circles, people commented on paintings. The middling and popular presses often covered exhibitions. Correspondents assumed that their readers knew what famous sitters normally looked like and were happy to compare sitters' different likenesses. And if polite society demanded cool, effortless conversation about art, people could always confess to their diaries and letters what they thought paintings really looked like. Although viewers' comments are

[340] Although see the unpublished work of Matthew Newsom-Kerr. I am grateful to Jonathan Reinarz for this reference.

[341] A. Secord, 'Botany on a plate: pleasure and the power of pictures in promoting early nineteenth-century scientific knowledge', *Isis*, 93 (2002), 28–57.

hardly plentiful – hence my not being able to confine this discussion to smallpox and royals – sources like these do help us to uncover how people saw portraits *as* portraits of the ill.

If viewers could infer that a sitter looked ill in a portrait, then they needed to know how diseases affected appearances (which would be painted). As well as looking at paintings, people were indeed aware of effects of diseases on the body's appearance and on artistic representation. Earlier we read snippets of contemporary feelings about smallpox; but it was not the only affliction that brought about noticeable visual changes. A range of visual cues attached themselves to different illnesses. Armed with the gestural knowledge derived from continual inspection of patients, Dr Andrew White thought the look of plague was quite plain to see, if not to describe:

> The countenance exhibited an appearance of terror mixed with anxiety and, as it were, claiming pity, which is difficult to describe, but which is well known to those who see plague patients, and is very characteristic of the disease.[342]

Awareness of this sort of visual cue was propagated in amateur artistic circles, too. In his *Artist's Repository*, Charles Taylor declared that:

> The numerous DISORDERS to which mankind are subject...whether acute or chronical, generally produce correspondent effects in the countenance. Some persons from their birth are afflicted with maladies, which, by preying on their constitution, induce melancholy, pain, peevishness; their faces are pale, wan, livid; the airs of their countenance dejected and despondent: more recent sufferings subject others to similar tokens. Some diseases express themselves evidently, such as jaundice, dropsy, &c...[343]

[342] A. White, *A Treatise on the Plague, More Especially on the Police Management of That Disease* (London, 1846), 141.
[343] Taylor, *Artist's Repository*, 141.

I am looking for examples of how people saw illnesses expressing themselves "evidently" in portraits. Evidence of this level of recognisability is evidence of a period eye attuned to illness in portraiture.

Press correspondents often recognised people as ill. The *Morning Post*'s pseudonymous 'Guido' wrote of two of Sir Joshua Reynolds' entries into the 1776 Royal Academy exhibition that

> The numbers 240 and 241, are the portraits of the Duke of Devonshire, and David Garrick, Esq.; – whether owing to his Grace, or the artist we cannot say, but there is a beggardly kind of madness in the former.[344]

The correspondent could not attribute the look to any actual illness, nor any intention on Devonshire's or Reynolds' part, but to an *impression* of illness. The portrait communicated an idea of madness that the correspondent considered visible in the paint. Thus the duke of Devonshire could be declared unambiguously mad: "there is" madness. The reviewer of the 1830 Royal Academy exhibition also got an impression of the effect of illness when he looked at Sir David Wilkie's portrait of George IV in highland dress:[345]

> In the large picture of his MAJESTY...in many particulars, the likeness is striking, and exhibits the ravages of time and ill-health in a much more decided degree than the last portrait from the pencil of the late president.[346]

In this particular portrait, of the king in highland dress, the impression of illness stuck because it was stronger than any impression another likeness gave – presumably Wilkie's

[344] *Morning Post*, 27th April, 1776, issue 1,094.
[345] Information on the portrait may be found at www.royalcollection.org.uk/collection/401206/george-iv-1762-1830; accessed 1 August, 2012.
[346] *Morning Post*, 4th May, 1830, issue 18,531.

Entrance of George IV at the Palace of Holyroodhouse (1828), which was based on the king's appearance c. 1822.

If general ill states were discernible, then particular diseases were also noticeable. Melancholy was commonly recognised. As we shall see, artists and sitters developed a standard motif for depicting the fashionable brooding that the disease brought on. And it was often noticed. Before painting his portrait of the poet Robert Southey, Sir Thomas Lawrence wondered whether its commissioner, Robert Peel, would "in the poet...like something that should separate the character from the grave repose of the statesman".[347] The *Morning Chronicle*'s Royal Academy exhibition reviewer accordingly noted of *Doctor Southey* that

> We must confess the doctor has...a lack-a-daisical look. He is sitting bolt upright on a green bank with his legs across, and his right hand in a very awkward situation, and seems to think about thinking. All this, however, is...quite proper and becoming in a Poet Laureat [except that he appeared] in danger of catching a cold.[348]

Critics waxed lyrical about Reynolds' 1783 portrait of *Elizabeth Stanhope* as 'Contemplation': "She appears thoughtful and melancholy: the scene is *moon-light*: and the objects introduced are correspondent to such a state of mind...the pensive air he has given her is too much in contrast with her usual animation and gaiety."[349] The contrast between a sitter's visible melancholy and their presumed nature was likewise crucial for Fanny Burney (1752-1840) when she, now Madame d'Arblay, met the duchesse d'Angoulême in 1815. D'Arblay was taken to see the duchess's portrait so "that I might make some acquaintance with her face before the audience."[350] Since Burney mentions being shown the portrait in the "salon of

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[347] Thomas Lawrence to Robert Peel, 5thJune, 1828, D. E. Williams, *The Life and Correspondence of Sir Thomas Lawrence, Kt* (London, 2 vols.., 1831), ii, 480.
[348] *Morning Chronicle*, 14th May, 1829, issue 18,615.
[349] *Painter's Mirror*, 1783, 226, in PMC exhibition reviews.
[350] F. Burney, *The Diary and Letters of Madame d'Arblay* (ed. C. Barrett, London, 7 vols., 1842-6), vii, 56.

the exhibition of pictures", we may suppose that she saw Marie-Denise Villers' portrait of the duchess, exhibited at the *Salon* in 1814 but since lost.[351] Importantly, Burney noted that "the portrait was deeply interesting, but deeply melancholy."[352] Indeed, Burney was subsequently taken aback by the duchess's "smile...so peculiarly becoming, that it brighten[ed] her countenance into a look of youth and beauty."[353] With her portrait in mind, the duchess's smile overturned what Burney thought was her look.

Indeed, certain sitters came to look ill. Looking ill in the eyes of a viewer was intimately tied to how a viewer conceived a sitter's overall identity. Take John Keats (1795-1821). Keats was immortalised in his friend Joseph Severn's deathbed portrait (Figure 6). This small pencil drawing was made, as Severn said, to keep him awake – to help him keep his vigil on the night of January 28th, 1821. He did not shirk from showing Keats' consumptive symptoms: Keats is exhausted, his hair matted against the "deadly sweat" of his forehead. This likeness was particularly exploited by those who wanted to feminise Keats. The image of what they saw as a delicate wasting (feminine) body suited their ends.[354] Alexander Pope's identity also came to be associated, as we will see, with melancholy[355] – but also with general anxiousness. Samuel Ireland remarked of a portrait of Pope among the frequenters of Button's coffeehouse that "there is a peevishness and anxiety in the lineaments of the face, that we find in most of his finished portraits, and which are so strongly characteristic of the man, as to leave no doubt of his identity" (Figure 39).[356] In another example that foreshadows the next chapter, Thomas Lawrence's *Francis I* was deemed a "remarkable display of mental poverty." The reviewer in the *Athenaeum* even wondered: "Could Lavater himself have invented a better illustration of the physiognomy

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[351] *Le Mercure de France*, 62, (January-February, 1815), 306; cit. www.siefar.org/dictionnaire/fr/Marie-Denise_Lemoine#Oeuvres; accessed 1 August, 2012.
[352] Burney, *Diary and Letters of Madame d'Arblay*, vii, 56.
[353] Burney, *Diary and Letters of Madame d'Arblay*, vii, 63.
[354] Cit. H. Smith, *Keats and Medicine* (Newport, 1995), 401.
[355] E.g. M. Noble, *A Biographical history of England, from the Revolution to the end of George I's reign, being a continuation of J[ames] G[ranger]'s work...* (London, 1806), 293-4.
[356] S. Ireland, *Graphic Illustrations of Hogarth, from Pictures, and Drawings, in the Possession of Samuel Ireland...* (London, 2 vols.. 1794-9), i, 38.

of a drivelling idiot, than Sir Thomas presented to his illustrious patron, in the portrait of ... Francis the First of Austria"?[357] Portraits that looked ill informed what people thought about sitters' identity.

Practices of looking and the recognition of illness also fed into art criticism; and the language of portraiture was used to describe illness. This again suggests that there was a close conceptual link between recognising ill appearances and speaking about art. Contrasting the singer's portrait with his state of health, Fanny Burney exclaimed about

> Poor [Gaspare] Pacchierotti's health – there's the other side of the picture! – his health is miserable. He has some dropsical complaint of the extremest suffering, which he bears with a patient resignation.[358]

Pacchierotti's bad health is described as the reverse of a (presumably healthy-looking) portrait. D'Arblay might well be invoking the satirical portrait (by James Bretherton after C. Loraine Smith) of a fresh-faced Pacchierotti and others giving *A Sunday Concert*, in which he smiles at John Wilkes' daughter Polly (a known admirer of the castrato) (Figure 40).[359] D'Arblay was in fact equally taken with the singer; and she had pasted a copy of this engraving into her extra-illustrated diary.[360] Critics also exploited this sort of language when surveying portraits. The *Examiner* noted in 1825 that

> Mr [Martin Archer] SHEE's brassy colour is become the chronic disease of his professional mind and practice. It particularly infects 395 *Portrait of A. Loughman, Esq.*[361]

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[357] *Athenaeum*, 1830, 331, in PMC exhibition reviews.
[358] Burney, *Diary and Letters of Madame d'Arblay*, vii, 369.
[359] BM Satires 6125; NPG D14563.
[360] See C. Harman, *Fanny Burney: A Biography* (London, 2000), 84.
[361] *Examiner*, 10th July, 1825, issue 910.

Thus could viewers detect literal and figurative illnesses in portraiture, even if no actual signs of suffering were manifest. Portraits could look ill at a figurative as well as purely visual level. Paintings, not just sufferers, were described in the language of illness. Indeed, to look ill was not just to appear ill, but also to be critiqued or judged – a point the next chapter shall pursue.

Conclusions

This chapter has revealed how portraits showed the signs of illness and how their sitters could be perceived as looking ill. We are therefore at the point where we can assess the significance of ill portraits.

Perhaps the chief significance is that portraits – as distinct from any other class of image – were the aptest way of articulating how an illness affected identity. Contemporaries consistently used portraits – and complemented them with text – to express the personal meanings of illness. Portraits enable the historian to see how the visible legacies of illness were invested with identity-related meaning. These portraits reveal contemporary understanding of the principles on which, and the techniques by which, the signs of ill health were shown. Paying attention – in a comparative way – to the circumstances of production and to a portrait's likely afterlife, we have seen that illness was more likely to be signified if the sitter had less influence on the making of a portrait; indeed, we saw that artists and commissioners went out of their way to adapt the portrait genre in order to signify a powerless king's frailties. Moreover, signs of illness were also more likely to be shown if the portrait's focus was not just about the sitter's appearance. William Thompson's portrait was as much about conveying his standing as a moral instructor as it was about conveying a faithful likeness of his face; so, too, Humfrey Wanley's pockiest portrait was as much about his identity as a scholar as it was about his apparent identity as a sufferer of smallpox.

A second significance of ill portraiture is that it discloses how portraits mediated the individuated facts of being ill. In the final analysis, different portrait transactions produced different significations of illness. There was no apparent sub-genre of ill portraiture, just portraits adapted to show signs of illness. From family portraits to frontispieces, from kings to commoners, from smallpox to mental instability and old-age frailty, the portrait genre was flexible to express the individual meanings of being and looking ill. The decisions whether to show and how to show an illness were an individual matter. Although individual, many artists and sitters exploited conventional motifs and design features, such as including allegorical figures, making dedications and adding inscriptions. Pockmarks and a rough face were conventionalised motifs of smallpox suffering, of the lasting manifestations of illness. Hygeia and Job were conventional allegorical figures who were invoked time and again. Dedications alluded to conditions and/or people involved in a sitter's illness, such as carers.

Third, portraits anticipated how they might be seen by others. For instance, the signs of illness were more likely to be displayed overtly if the 'showing' portrait was not intended for wide (public) circulation. Illness was, then, a fundamental part of the imagined or intended social 'matrix' of a portrait.

A fourth significance of ill portraits is therefore that they enable historians of medicine to understand how contemporaries were visually attuned to the signs of illness. Viewers recognised and interpreted the signs of illness and suffering. They also inferred such signs, regardless of any intention on the part of artists and sitters. And they linked their perceptions of such signs to what they thought about sitters' identity. Moreover, viewers' perceptions of ill health infused the language of art criticism, while a healthy portrait could stand for health more broadly. In these ways, the relationship between health and the visibility of illness in portraiture assumed figurative qualities.

The decisions, choices and responses of artists, sitters and viewers reveal how portraits were social objects. A fifth significance, which relates to this and the variety of

portrait transactions, is that ill portraits show how many different historical actors instilled meaning into illness. Artists, sitters, engravers, printers and viewers all contributed to the construction of the meaning of illnesses, and the meaning of the appearance of illnesses. This insight is achieved only by refusing to wrestle the representations of illness away from their artistic contexts. Portraits reveal that meanings of illness are not generated only by 'society', or by 'culture', or by sufferers alone. Rather, portraits freeze-frame clusters of meanings generated by being represented as a sufferer.

Indeed, portraits were part of a dialogue about what it was to suffer and be ill, and about what it was to show these states. Portraits were communicative objects in this sense. They transmitted ideas about the relationship between health, illness and identity. They related the physical and visible to the non-physical and the imaginary. Indeed, personhood and identity – the key distinguishing concerns of portraiture, as distinct from other image genres – were a complex of the physical and the non-physical. The non-physical part of personhood and identity was character. Long eighteenth-century society took similar cognitive steps to those evinced in this chapter in thinking that portraiture could communicate character. We shall now pursue portraiture's idea-communicating abilities by interrogating how people assessed character through 'ill portraits'.

Chapter II – Portraits, illness and character

Introduction

We have begun to see that portraits were made in the first instance because they were thought to express something about identity – be that the identity of the sitter(s) or perhaps of the artist(s), too. The first chapter suggested that portraits were made to express something about identity as it was visibly affected by illness.

Like all images, portraits carried information.[362] In particular, according to early-modern understandings and expectations, portraits carried information about character traits, life-experiences, ancestry and status as well as (supposed) appearance. Indeed, a 'good' likeness need not have conformed to any expectations of a 'real' likeness at the time of sitting.[363] Rather, a good likeness was one that well conveyed this ensemble of information.[364] The sum of information contained in a portrait best connoted one's identity.

Portraits, of course, were not the only 'things' of early-modern culture that were invested with the ability to express character and hence identity. Clothes, homes, works and possessions all sent out signals about who people were and what they wanted others to see and infer.[365] Portraits, however, were unique for conferring meaning onto representations of the body. Part of portraiture's ability to express character rested on the body's ability to do so. Strength, rectitude, holiness, wisdom, probity, self-discipline, fertility, civility, elegance, taste, and refinement were all discernible through comportment – one's control

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362 See J. Elkins, 'Art History And Images That Are Not Art', *The Art Bulletin*, 77, 4 (1995), 553-71.
363 See H. Berger, *Fictions of the Pose*: *Rembrandt against the Italian Renaissance* (Palo Alto, CA, 2000), 89, 99.
364 Cf. J. Woodall, 'Pre-face', paper delivered to the 'Likeness and Facial Recognition' workshop, National Portrait Gallery, London, UK, 11thFebruary, 2011.
365 L. Auslander, 'Beyond Words', *American Historical Review*, 110, 4 (2005), pp. 1015-45; D. Roche, *A History of everyday Things: The Birth of Consumption in France, 1600-1800* (Cambridge, 2000); J. H. Plumb, J. Brewer and N. D. McKendrick, *The Birth of a Consumer Society: The Commercialization of eighteenth-century England* (London, 1982); Vickery, *Behind Closed Doors*; U. Rublack, *Dressing Up: Cultural Identity in Renaissance Europe* (Oxford, 2010).

of one's body – and bodily markers. Many of these markers relied on good health: supple legs for a graceful walk, or a sound mind for temperance, and so on. Good health implied a good character. Likewise bad health implied a bad character. The body, therefore, was a medium of social and cultural differentiation –a way of telling good characters apart from bad ones.[366] Indeed, these assumptions align closely with those that spurred the 'reformation of manners' in early-modern culture.[367]

The body was also a field of medicine.[368] Medical practitioners had a stake in controlling knowledge, judgments and opinions about bodies. This was exemplified by the notorious 'rabbit-breeding' case of Mary Toft in 1726, where doctors hotly debated the (fake) phenomenon of a woman giving birth to rabbits.[369] If categories of health and illness altered, so were judgments about people's character liable to change.

This chapter interrogates the nature of the link between portraits, health, character and identity. I shall consider how portraits could convey information about sitters' health and so about their character – how they could encourage inference about the non-physical from the depiction of the physical. I argue that portraits developed and deployed leitmotifs, tropes and other devices to signal how sitters were or were not affected by certain conditions. They could imply or rebut associations to illnesses that would affect how a sitter's character was perceived. Similarly, I argue that portraits engaged in social discourses, responded to cultural beliefs, challenged norms and exploited the tendency of early-moderns to infer from and judge on what was seen. The 'illness information' portraits conveyed made them weapons in sitters' representational arsenals. The examples below also show how portraits were used with texts; together they amounted to a potent representational armoury. This chapter does not try to judge whether their efforts were

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366 Cit. V. Kelly and D. von Mücke, 'Introduction: Body and Text in the Eighteenth Century', in *eaedem* (eds.), *Body and Text in the Eighteenth Century* (Stanford, 1994), 7.

367 Cf. M. E. Wiesner-Hanks, *Early Modern Europe, 1450-1789* (Cambridge, 2006), 258-9.

368 Cf. P. Bourdieu, *The Field of Cultural Production: Essays on Art and Literature* (trans. R. Johnson, New York, 1993).

369 D. Todd, *Imagining Monsters: Miscreations of the Self in Eighteenth Century England* (Chicago and London, 1995), 1ff.

successful or in vain. Rather, it simply tries to present what sitters thought portraits could do for their health-dependent 'image'.

I have chosen two 'maladies' to analyse. One affected the mind: melancholy. The other could affect both the body and the mind: deformity. Both of these are contemporary notions. The chapter's focus will be on deformity, because 'melancholic' portraits have already received some art-historical attention.[370] Accordingly, I will weave the discussion of melancholy into a broad preliminary discussion of the forces partly shaping the relationship between portraits, bodies and matters of health in the eighteenth century. These forces affected how people formed ideas about each other. They include publicity, curiosity and physiognomy.

The overall structure of the chapter is therefore as follows. First I introduce how health and portraiture could 'go public'. This sets up the discussion of melancholy. I argue that a melancholic pose associated sitters to erudition and creativity; it was a trope that revealed elements of their personalities and occupations. After this, I step back to survey how likenesses related to (potentially public) caricature, how likeness impinged on one's character, and how early-modern culture developed specific ways of looking at the body. In particular, I shall detail a phenomenon that was all to do with looking at the irregular or unusual: curiosity. I shall then move on to discuss deformity, a bodily irregularity that was subject to curious looking and that caused people to judge character. This paves the way for the three case-studies of deformity: I compare Alexander Pope, the poet, with William Hay, MP for Seaford, and Josef Boruwlaski, a celebrated dwarf.[371]

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[370] Esp. R. C. Strong, *The English Icon: Elizabethan and Jacobean Portraiture* (London, 1967), 352ff.

[371] For a basic comparison of these three, see Anon., "'Lively Little Creatures", "Mis-Shapen Beings", or "Masterpieces of Workmanship"? Constructions of Dwarfism in Eighteenth-Century England', M.A. thesis, King's College London, 2010. I am grateful to Ludmilla Jordanova and the anonymous author for allowing me to see this proof. Portraits are mentioned briefly in passing at 5-6.

Portraits, health and public image

As the Introduction explained, early-modern Britons were medically knowledgeable. They did not just know about their own health and medicine. Health was a matter of broad social concern. Medical matters often became public knowledge, and gossip could spread quickly in many forums. Wayne Wild has shown that personal illnesses were a legitimate topic for letter-writers, for instance.[372] Newspapers also carried reports of illness. Gossip on monarchs' and celebrities' health was especially rife. The *London Evening Post* wrote on 28thSeptember, 1734 that "[t]hey write from Bath that Mr. [Alexander] Pope...is dangerously ill." Pope had to write in to deny the rumours.[373]

If health was public, so were portraits. People recognised likenesses even of those they had never met and were never likely to meet. Coins typify how people could absorb and recognise likenesses at a distance.[374] In many senses, however, portraits went further than being a simple means of recognition. Likenesses could be visual cues. Pope's head swung on the sign of Edmund Curll's bookshop, like an unauthorised product endorsement.[375] Pope's face became a face of literature *tout court*.

Portraits were also involved in reputation management. They were thought to be able to mould viewers' minds and therefore to shape the public opinion of sitters.[376] As David Solkin has shown, portraits helped to cast Thomas Guy, the medical philanthropist, as a charitable man who worked for others' benefit in his own lifetime, not just providing for them on his death as his detractors argued. Symbols like the beehive and allegorical figures like Hygeia were trooped out by his defender-artists to depict Guy as a latter-day

372 W. Wild, 'Medicine-by-post in eighteenth-century Britain: The Changing Rhetoric of Illness in Doctor-Patient correspondence and literature', Brandeis Uni. Ph.D. thesis, 2001, 36-7.
373 *Correspondence of Alexander Pope*, iii, 436, n. 3.
374 See Brown, *British Historical Medals*.
375 C. Ingrassia, *Authorship, Commerce, and Gender in Early Eighteenth-Century England: A Culture of Paper Credit* (Cambridge, 1998), 72.
376 For an overview, see M. Rosenthal, 'Public Reputation and Image Control in late Eighteenth-Century Britain' *Visual Culture in Britain*, 7, 2 (2006), 69-92.; Pears, *Discovery of Painting*, 182; Ray, 'Talking About Art', 530-2.

Samaritan. Inscriptions also emphasised the fact that he founded his hospital before he died (Figure 41).[377]

Similarly, Ludmilla Jordanova has shown how Allan Ramsay's portrait 'softened' the image of the surgeon and man-midwife, William Hunter (Figure 42). Ramsay's Hunter was a gentleman first and foremost. The portrait drew out "general features that happened, contingently, to belong to a medical practitioner".[378] Jordanova has claimed that several medical men created "alterative images" of themselves by and through their portraits.[379] In each instance, a portrait presented a sitter as a certain type of character. This newly presented character invariably differed from how a sitter thought he was perceived at the time of the portrait(s).

I find Erving Goffmann's concept of a 'front' quite useful in conceiving of the role of portraits in these situations.[380] According to Goffmann's original dramaturgical formulation, a front is that part of a person's 'performance' that seeks to define what others see. A front allows others to understand someone on the basis of the character that he or she projects. Indeed, a front is all to do with "impression management".[381] Later in his work on 'stigmas', Goffmann imagined a front to be a cross between a filter of information about someone and a projector of "disidentifiers".[382] That is, it is a sort of visual-cum-behavioural artifice created by someone who attracts attention by suffering from some bodily irregularity. Such a front was set up between him and the 'stigmatising' eyes of a viewer.

Goffmann helps us to consider any instance in which a person sought and by his own agency helped to fabricate an image of himself that would affect how he was seen and therefore thought about. As artificial intermediaries between the actual sitter-person and

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[377] D. Solkin, 'Samaritan or Scrooge? The Contested Image of Thomas Guy in Eighteenth-Century England', *Art Bulletin*, 78, 3 (1996), esp. 471, 479, 481ff.
[378] Jordanova, 'Medical men', 110.
[379] Jordanova, 'Medical men', 101.
[380] E. Goffmann, *The Presentation of Self in Everyday Life* (London, 1990).
[381] Goffmann, *Presentation of Self in Everyday Life*, 208.
[382] E. Goffmann, *Stigma: Notes on the Management of Spoiled Identity* (Harmondsworth, 1968), 44.

viewers, in an age when artifices did not necessarily bar full recognition of someone,[383] portraits were an ideal medium for sitters to project identifiers and disidentifiers. Indeed, the subjects of this chapter were actively involved in what Goffmann conceived of as impression management.

Melancholy

One of the ways a portrait could present an image or front – and so suggest something about character – was by suggesting that a sitter suffered certain conditions. If a condition implied a certain sort of character, then getting across that a sitter suffered from it would imply that the sitter possessed that character. Melancholy shows this very neatly. Portraits were a perfect tool for casting an image of oneself as a sufferer from an illness that implied certain agreeable character traits.

Melancholy in the eighteenth century referred to the seizure of the mind by solemn, brooding, dejected contemplation. Contemporaries tended to explain it either by the motion of Saturn, a slowing of animal spirits, a disorder of the nerves, or an excess of black bile. It was considered similar to – though distinct from – conditions such as the 'spleen' and the 'vapours'. Yet if melancholy occasioned despair, anguish and sorrow, it could equally inspire great creativity and flashing moments of lucidity, like sunlight catching a mirror. As such, it was thought to be suffered only by those with active, clever, discerning minds. Along with its association to sensibility and feeling – and therefore to politeness – this made it a fashionable disease in our period.[384]

[383] Nor were artificial interpositions a barrier to acquiring knowledge generally. Only really when such artifices were deemed to interrupt chains of causation did they become problematic. This was predicated on a (slow and erratic) epistemological shift towards trying to interpret laws of nature rather than signs of nature. For one account of this in actions, see M. Hagner, 'Enlightened Monsters', in W. Clark, J. Golinski and S. Schaffer, *The Sciences in Enlightenment Europe* (Chicago, 1999), 175-217.

[384] See Lawlor, 'Fashionable Melancholy'. See also D. Buie, 'Melancholy and the Idle Lifestyle in the Eighteenth Century', Uni. of Northumbria Ph.D. thesis, 2010, esp. 9ff. Buie discusses melancholy in relation to idleness: creativity was a means of dispelling idleness, e.g., *ibid.*, 162.

The conventions for the way melancholy was represented in portraits were established in the early sixteenth century. Albrecht Dürer's iconic allegorical engraving of *Melancolia I* (1514) showed the despondent winged figure of Genius slumping and resting its hand on his head in world-weariness, as though searching for some far-off answer. The trope of this pose was taken up by the early-modern British authority on melancholy, Robert Burton's *Anatomy of Melancholy* (1628). The frontispiece shows two figures adopting Dürer's pose: Democritus sitting wistfully beneath a tree and a gowned scholar reflecting at his desk (Figure 43). Roy Strong has shown how many Elizabethan and Jacobean portraits depicted sitters in dark, almost sepulchral settings with the Dürer-Burton pose.[385]

It is important to remember how contrived this pose was. It was developed precisely for the outward expression of the condition in visual media. It was not a physiologically inherent visible symptom. It need not have been obvious – but was made obvious. The very contrivance of the melancholic pose is the first clue to portraiture's active role in identity management. The same contrivance is visible, for instance, in the crossed-legged, hand-in-waistcoat pose of some well-to-do sitters' portraits of the early nineteenth century; that pose betokened their status as gentlemanly men of leisure.[386]

Many long eighteenth-century sitters claimed to be melancholic and duly adopted the pose. I begin with Alexander Pope (1688-1744), the poet mentioned a few times already. I shall introduce him more fully later, but suffice it to say for now that Pope, as a feted poet, was a 'celebrity' figure and that his iconography was vast.[387] His iconography started with a stiff and rather pompous portrait by his friend and room-mate, Charles Jervas. He was then portrayed twice by Sir Godfrey Kneller, the premier artist of his day – first holding triumphantly his then-signature translation of Homer's *Iliad*, and second in

[385] Strong, *English Icon*, 352ff.
[386] With this, cf. A. Meyer, 'Re-dressing classical statuary: the nineteenth-century 'Hand-in-Waistcoat' portrait', *Art Bulletin*, 77, 1 (1995), 45-64.
[387] See W. K. Wimsatt, *The Portraits of Alexander Pope* (New Haven, 1965).

laureate profile.[388] A few years later, in 1722, Kneller portrayed him for a third time. An older thinner man sits resting his head on his hand in the melancholic pose. Pope had spoken of his (humoural) melancholy as early as 1714 and continued to do so in later life. (Indeed, he once claimed that his friends were "All Air and Fire, while I am Earth".)[389] But it is only after having achieved celebrity and renown for his intellect that Pope claimed the illness in his portraiture. It signalled his (own sense of his) apogee as a thinker. He had nothing else to show but his mind, by which alone he desired to be known. The representation of melancholy allowed Pope to draw on its rich associations of learning and creativity, to make a statement about his work, and therefore to express something about his mind and self.[390] The association to melancholy was confirmed in the way this likeness was reproduced. For instance, it was reproduced in 1732 by George White in a brown ink mezzotint (Figure 44).[391]The whole engraved surface shows just the head and the hand resting on it. White zoomed in on Kneller's rendition, like some magnified examination of Pope's head. It not only emphasises the pose, but also the head as the site of Pope's intellect.

Pope adopted the melancholic pose again after Kneller, but the tone of it changed. About a decade after Kneller's second portrait, Jean-Baptiste van Loo depicted Pope in the pose. So did the jack-of-all-art-trades, Arthur Pond. Their portraits convey less of the brooding desperate quality of Kneller's, but rather capture the 'other set' of symptoms: the sort of relaxed far-off wonderment of easy creativity. This suited Pope as a poet to whom the "numbers came" effortlessly.[392] Like Kneller's before them, these likenesses were copied copiously, even after Pope died. Importantly they wound their way into the prestigious historical biographies of the mid-to-late eighteenth century where Pope's fame

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388 The honour of poet laureateship would elude him as a Catholic.

389 *Correspondence of Alexander Pope*, i, 195; iv, 231. With this, cf. Wear, *Knowledge and Practice*, 39.

390 For a different spin on Pope's portraits' relationship with his "authorial image", see H. Deutsch, 'The "Truest Copies" and the "Mean Original": Pope, Deformity and the Poetics of Self-Exposure', *Eighteenth-Century Studies*, 27, 1 (1993), 1-26, esp. 2ff.

391 WL (uncatalogued).

392 Pope., 'To Arbuthnot', l. 128.

as a poet was – perpetuated by others – bound up with his representation in portraiture. Jacob Houbraken engraved Pond's elaborately decorated portrait after Pond for Thomas Birch's *Heads of Illustrious Persons* (Figure 45). Both Pond's and van Loo's portraits appeared in Henry Bromley's 1793 compendium of engraved portraits. Pope's melancholic pose became fastened to his renown as a creative man.[393]

Many other portraits testify to the endurance of the pose for creative people. Portraits by Caspar Netscher and Peter Lely presented William and Dorothy Temple as a marriage of melancholics, extending their reputations as persons of letters.[394] Horace Walpole's dashing portrait of 1756-7 by Sir Joshua Reynolds presented Walpole in a cool stance, exuding all the relaxed confidence of a man of the world (Figure 46). But Walpole kept the melancholic pose to remind the viewer of the hard-work of his mind. He was, after all, a creative man of letters *par excellence*. The painting in fact draws the viewer's eye to the pose: Reynolds shrouded Walpole's pose in a little brighter light, from the right of the head, round and down to the cuff of his shirt. This light creates a frame within a frame – a bit like White's re-framing of Kneller's view of Pope.

Reynolds also painted anatomist and surgeon John Hunter, William's brother (Figure 4). As described in the last chapter, it shows a surgeon surrounded by *materia medica*, the objects of his study and profession: a skeleton, a lavishly engraved book, preparation jars and so on. Note Hunter himself. Here is a gentleman – just like his brother – not a knife-wielding surgeon. Here is a thinker, portrayed amid books in a moment of reflection. Hunter's head rests on his hand – ready to pen his 'eureka' thoughts. As also mentioned earlier, surgeons were especially keen in this period to be thought of as more than brutal knife-wielders and bloody dissectors – indeed as men of the mind and pen as much as the hand. They aspired to the same learned reputations that physicians had gained and jealously

[393] On extra-illustration, see esp. Peltz, 'Facing the text'.
[394] NPG 3812, 3813: see Ingamells, *Later Stuart Portraits*, 282 (and nn. 2-3), 284 (and nn. 3-4).

guarded.[395] Other 'professionals' wanted to profit from such reputations, too. Compare, for instance, the cleric-cum-writer Lawrence Sterne with the engineer James Watt – 'melancholics' both (Figures 47 and 48). Melancholy was a way for these people to suggest something about the creative and intellectually demanding nature of their work that they were known for (and that is visible on their respective desks). Thus melancholy impressed on people ideas about sitters. Sitters' self-association to melancholy affected how they presented their identity.

Lest we think that it was just high-standing men who adopted the melancholic pose, let us dwell for a moment on Selina Hastings, Countess of Huntingdon (1707-91). She is often remembered as one of the aristocratic women who heckled the House of Lords in 1739 (when England was parleying for peace with Spain) and as a religious zealot, the founder of her eponymous dissenting Connexion in 1782. She was known generally in her time as a woman of solemn and sometimes acerbic character, even of depressed temperament and hypochondriac tendencies.[396] Her portraits came to play on these reputations. Since the 'normal' behaviour of a melancholic was remarkably similar to the behaviour she exhibited(or was described as exhibiting), the pose rendered her behaviour culturally acceptable.

Her first portrait in 1773 gives no indication of melancholy (Figure 49). Fast-forward to the 1780s, however, and her anonymous oil portrait seems almost *entirely* to make an issue of the pose (Figure 50). Selina stares at the viewer head on. She avoids the far-off gaze but fixes the painter's and the viewer's. Her arm appears almost as a shaft of creamy light flashing upward, drawing the viewer's eye to the chief prop of the melancholic pose: the three outer fingers of her left hand curl downwards, while the index finger points to the head. She is literally acknowledging her own use of the pose to the viewer –

[395] For more on medics' melancholy, see L. J. Jordanova, 'Melancholy reflection: Constructing an Identity for Unveilers of Nature', in *eadem*, *Nature Displayed*, 69-85.
[396] DNB. Even her early panegyrics acknowledge it, though it was easily yoked to her piety: see A. C. H. Seymour, *The Life and Times of Selina, Countess of Huntingdon* (London, 2 vols., 1839-40), i, 16, 26.

demonstratively encouraging the viewer to recognise it. Not only does the pose point to the head, but the whole canvas frames it – along with the book and glasses that her mind has been contemplating. It is unusually close-up, again like White's engraving of Pope. The very composition of Selina's portrait acts again like a magnifying glass over the pose. The viewer is also drawn to her ruefully smirking lips. They signal that she realises that adopting the pose is all it took to render her behaviour acceptable rather than untoward.

The combination of frontal stare and rueful smirk goes against many grains of conventional portraiture, which prescribed neutral unemotional expressions that would better indicate permanent character, not temporary fluctuations of mood.[397] The fact that Huntingdon and her artist chose not to adopt such a neutral expression only further suggests that the portrait was a provocative play on her supposedly permanent character, the reputation of which they could quite easily overturn.

Huntingdon's later portraiture was just as persistent, though less provocative. In 1790, she reverted to the more standard three-quarter length oblique pose in a line engraving by James Fittler after Robert Bowyer (Figure 51). It depicted her with her arm slightly hidden and with the objects of creative reflection in front of her. She continued to present the image of a permanent melancholic, albeit less forcefully than before.

Melancholy, then, was a disease whose symptoms, captured in a stylised pose, provided endless fuel for the identity-promotion forge. If, as George Rousseau has argued, one was 'sick' only when one submitted to tropes of suffering, then portraits provided a way of activating such tropes.[398] Portraits exploited the melancholic pose as a signifying tag, associating sitters to the illness in order to make a point about who they were, whether professionally or personally.

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[397] See for instance Lessing's *Laocoön* (1766), described in M. Yonan, 'The Man behind the Mask? Looking at Franz Xaver Messerschmidt', *Eighteenth Century Studies*, 42, 3 (2009), 431-51, at 442-4; cf. West, 'Wilkes' Squint', 78.

[398] G. S Rousseau, 'Literature and Medicine: Towards and Simultaneity of Theory and Practice', *Literature and Medicine*, 5 (1986), 152-181, at 171.

Satire and caricature

One reason why sitters might have taken such an interest in making sure their portraits expressed what they wanted them to express, was that portraits were not the only abundant visual medium that claimed to be able to assert character. Satires purported to do just the same thing. And the long eighteenth century was without doubt an age of satire. As scholars like Dorothy George, Vic Gatrell and Linda McCreery have shown, satires, graphic cartoons and caricatures were rife and widely consumed.[399] Even if it pushed the point, the *Morning Chronicle* captured a mood when it reported in 1796 that

> The taste of the day leans entirely to caricature...We are no longer satisfied with propriety and neatness, we must have something grotesque and disproportioned.[400]

If viewers were aware of likenesses, then they were also aware of "grotesque and disproportioned" likenesses that had been purposefully warped. Viewers recognised stand-in associative symbols, for instance, which allowed them to work out who or what was being sent up. A boot came to stand for the earl of Bute, George III's favourite and prime minister (see Figure 52). Satires even developed different motifs for sending up different social groups.[401] In what Shearer West has called the "emblematic culture" of the long eighteenth century, corporeal markers and made-up symbols were a powerful combination – mainly because they correlated metonymically with abstract values.[402] Satires assigned values to people. Just like in portraits, they contained visual cues that called viewers' attention to personal qualities and character traits.

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[399] F. G. Stephens and M. D. George, *Catalogue of Political and Personal Satires preserved in the Department of Prints and Drawings in the British Museum* (London, 11 vols.., 1952); C. McCreery, *The Satirical Gaze: Prints of Women in Late Eighteenth-Century England* (Oxford, 2004); V. A C. Gatrell, *City of Laughter: Sec and satire in eighteenth-century London* (London, 2006).

[400] Cit. Youngquist, *Monstrosities*, xxiv.

[401] C. Smyliotopoulos, 'Rewritten and Reused; Imaging the Nabob through 'Upstart Iconography", *Eighteenth-century Life*, 32, 2 (2008), 39-59.

[402] West, 'Wilkes' Squint', 69.

Caricatures specifically took the body as their cue. They purposefully skewed representations of people's bodies for (pointed) comic effect. Common to all the contemporary rules and standards of caricature was the exploitation of a known oddity or distinguishing feature. In Hogarth's *Characters and Caricaturas* (1743), caricature was simply the gross exaggeration of facial features. Francis Grose later made the link to identity and norms of beauty. As he put it in his *Rules for Drawing Caricaturas* (1788):

> A slight deviation from them [European ideas of beauty], by the predominancy of any feature constitutes what is called *Character* and serves to discriminate the owner thereof, and to fix the idea of identity. This deviation or peculiarity, aggravated, forms Caricatura.[403]

Grose went on to warn against "aggravating" the likeness too far. Caricatures could become "overloaded", thereby making the subject's identity unclear.[404] Importantly, caricatures drew strength of meaning from existing fixed ideas of people's identity. This implies some dialogue between images. Equally crucially, caricatures and their motifs could play on known illnesses. For instance, the duke of Portland's gouty legs led to satires portraying him with legs of his eponymous stone – as in Charles Williams' *John Bull contemplating a statue of Portland Stone* (Figure 53).[405]

Given these points, it is worth pursuing how satires and portraits might have played off one another in their bid to assert a person's illness-affected identity. One example of this sort of work is West's study of John Wilkes (1725-97). Wilkes had a squint, which was seized on by his critics. One attacker of his 'seditious' *North Briton* said:

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[403] F. Grose, *Rules for drawing Caricaturas* (London, 1788), 5.
[404] D. Lynch, 'Overloaded Portraits: The Excesses of Character and Countenance', in Kelly and von Mücke (eds.), *Body and Text*, 112-43, esp. 114-5, 127. Cf. Stafford, *Body Criticism*, 217.
[405] BM Satires 10718.

> I have seen a [Hogarth] print of you.... Your face is the indication of a very bad soul within...the least judge of physiognomy, may see you a scoundrel at one view.[406]

By a stroke of what West calls "synecdochic physiognomy", squints were associated with duplicity and sexual excess. Such an unsightly face bespoke a sullied character. Yet Wilkes re-appropriated his squint over the course of many years and many public portrait prints. Gradually, it entered the popular consciousness as a mark of the values he stood for, most obviously liberty.[407] In West's words, the squint had passed from "caricature to iconicity".[408] That was phase one of the symbolic re-appropriation. Later, in his portrait taken by Johan Zoffany (with his daughter Polly, exhibited in 1782 on Wilkes' becoming Lord Mayor), Wilkes is shown with an obvious squint (Figure 54). The public symbol was reclaimed by the private man. No longer would it stand only for his public values. Having "assimilated and neutralized the invective" of the caricatured marker/symbol, Wilkes, in phase two of the re-appropriation, made it stand for his private persona.[409] In other words, Wilkes – along with his artists – tried to reformulate his public character by reformulating synecdochic bodily markers.

Health, character and appearance: physiognomy and curiosity

As Wilkes' example indicates, people inferred things about character from the way people looked. Portraits and satires were common 'vehicles' of character suggestion and inference. People looked at bodies for all sorts of clues. Indeed, entire disciplines were founded on the neo-platonic assumption that the outward body could reveal the inward person.

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406 Cit. West, 'Wilkes' Squint', 65.
407 West, 'Wilkes' Squint', 76.
408 West, 'Wilkes' Squint', 74.
409 West,' Wilkes' Squint', 66, 70, 77ff. For more on Wilkes, see J. Simon, 'Disability in the Eighteenth Century – A National Portrait Gallery Trail', www.culture24.org.uk/art/live+%26+public+art/tra41901, accessed 19th July, 2011.

Accordingly, there was correspondence between form (shape) and nature (quality or function). Unbroken epistemic lines connected resemblance with character and sight with cognition.[410]

Physiognomy was one discipline based on such premises. Barbara Stafford, Sharonna Pearl and Lucy Hartley have shown how physiognomy claimed to make sense of the ability of surfaces and shapes to reveal inner properties.[411] Johann Lavater, the major eighteenth-century theorist of physiognomy, devised how ratios and angles of different parts of the body – chiefly the face – could reveal differences between class, cleverness, nationality and race. Spots and warts on the skin also indicated moral and racial decline from Greek perfection (see below).[412] Later in our period, indexes like the shape of the cranium and the contours of the surface of the skull would be analysed.[413] So the body – whether in part or in whole (cf. chap. III) – had visible meanings.[414] Pathognomy was another discipline that relied on the assumed synchronisation of mind and body, specifically the actions of the muscles. Facial expressions could suggest prevailing passions and therefore prevailing temperament. Particularly in the earlier years and then toward the end of our period, great efforts were made to construct facial typologies of the passions.[415]

Such disciplines contributed to categories of characterisation. Yet they were not the only cultural trends that extracted character and created differentiating categories from bodily appearance. Curiosity was another. Curiosity denoted the urge or "habit" to enquire into – and be almost bewitched by – the irregular, the singular or the wondrous.[416] The noun 'curiosity' and the adjective 'curious' covered a wide spectrum of people and

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[410] This assumption was not universally accepted, but it is fair to say that it predominated; cf. Stafford, *Body Criticism*, 126ff.

[411] Stafford, *Body Criticism*; S. Pearl, *About Faces: Physiognomy in nineteenth-century Britain* (Cambridge, MA, and London, 2010); L. Hartley, *Physiognomy and Meaning of Expression in Nineteenth-Century Culture* (Cambridge, 2006).

[412] Stafford, *Body Criticism*, 285.

[413] See R. Cooter (ed.), *Phrenology in Europe and America* (London, 2001).

[414] Cf. D. Wahrman, *The Making of the Modern Self: Identity and Culture in Eighteenth-Century England* (New Haven, 2004), 297.

[415] E.g. Parsons, *Human Physiognomy Explain'd* (London, 1747); Bell, *Anatomy of Human Expression*; cf. Hartley, *Physiognomy and Meaning of Expression*, 15, 19ff and Gouk and Hills, *Representing Emotions*, 21.

[416] B. M. Benedict, *Curiosity: A Cultural History of Early Modern Enquiry* (Chicago and London, 2001), 2.

practices.[417] It was a means of differentiating both those who practised curiosity and those who were the objects of curiosity. For instance, in the domain of natural philosophy, curiosities were singular specimens, novel experiments and the like. (The rabbit-breeding of Mary Toft went down as one.)[418] In this domain, curiosity itself was a prestigious mode of enquiry that connoted learning and bestowed distinction on those that practised it, most notably the members of the Royal Society inspired by Francis Bacon.[419]

In the domains of health and appearance, by contrast, curiosity probed visible bodily difference, including deformity (as we shall see below). Such probing could be considered scholarly and respectable or idle and gratuitous, depending on who was being curious, where they were being curious and with what purpose.[420] Idle curiosity, the sort gratified by the sight of bodily difference, prompted a response of open-mouthed wonderment. According to Katharine Park and Lorraine Daston, such wanton fascination cast the idly curious as "vulgar" in contradistinction to the 'civilised' natural philosopher.[421] In this cultural domain, 'curiosities' were those who displayed bodily difference.

However it ramified, the general fascination with unusual bodies had many consequences. First, it affected how people were displayed. Second, it affected how people looked at other bodies. And third, it affected how character was inferred from bodily display. This makes it trebly relevant to portraiture, which encouraged all three processes of displaying, looking at and inferring from bodies.

Unusual bodies were apt to be displayed and stared at. Monsters were frequently exhibited to satisfy the idly curious – for instance at Charing Cross, Southwark Fair and

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417 P. F. Da Costa, 'The culture of curiosity at the Royal Society in the first half of the eighteenth century', *Notes and Records of the Royal Society*, 56 (2002), 147-66, at 147-8.

418 Benedict, *Curiosity*, 21

419 See generally, P. F. Da Costa, *The Singular and the Making of Knowledge at the Royal Society of London in the Eighteenth Century* (Newcastle, 2009); *eadem*, 'The culture of curiosity'.

420 Da Costa, 'The culture of curiosity', 152f; see also, Stafford, *Body Criticism*, 262ff.

421 K. Park and L. Daston, *Wonders and the Order of Nature, 1150-1750* (New York, 1993), 331; cf. Da Costa, 'The culture of curiosity', 153f. Over 100 papers of the *Philosophical Transactions* were to do with some form of monstrosity; often this was because they could test anatomical theories: see J. Moscoso, 'Monsters as Evidence: The Uses of the Abnormal Body During the Early Eighteenth Century' *Journal of the History of Biology*, 31, 3 (1998), 355-82, esp. 358-60.

Bartholomew Fair.[422] Even workhouse masters charged people to see their curious poor.[423] People paid money simply to look at unusual bodies. Exhibitions were unashamedly advertised in the press.[424] Adverts claimed that only looking could give the fullest impression of curiosity. For instance, the giant body of Charles Byrne had to be seen to be best appreciated.[425] The *Morning Herald* on the 6th May, 1782 claimed that

> Neither the tongue of the most gifted orator, or pen of the most ingenious writer, can sufficiently describe...this wonderful phenomenon in nature...all description must fall infinitely short of giving that satisfaction which may be obtained on...inspection.

The public anatomy museums and "eccentric" biographical compendia of the early-to-mid nineteenth century simply took exhibitions like Byrne's behind closed doors – rendering the practices of looking more furtive but no less popular.[426]

As Guy Debord noted, 'spectacles' like exhibiting curiosities are "social relation[s]...mediated by images."[427] Portraits provided an outlet for looking at the curious. Portraits channelled the urge to gaze at bodily difference.[428] They catered for all types of viewer and all purse sizes. On the one hand, dwarf Peter Bono had portraits made of him costing ½*d.* each.[429] On the other hand, James du Plessis' limited edition *Short History of Human Prodigies* (1730) was expensively published with 54 hand-coloured drawings per

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[422] The word monster derives from the Latin *monstrare*: to show. Hogarth's print of *Southwark Fair* shows Maximilian Miller exhibiting himself. See Caulfield, *Remarkable Persons*, 110.
[423] See e.g. Caulfield, *Remarkable Persons*, 148ff.
[424] The best introduction is still R. D. Altick, *The Shows of London: A Panoramic History of Exhibitions, 1600-1862* (Cambridge MA, 1978).
[425] His skeleton is in the Hunterian Museum.
[426] A. W. Bates, "'Indecent and demoralizing representations": Public Anatomy Museums in mid-Victorian England', *Medical History*, 52, 1 (2008), 1-22; H. McHold, 'Even As You and I: Freak Shows and Lay Discourse on Spectacular Deformity', in M. Tromp (ed.), *Victorian Freaks: The Social Context of Freakery in England* (Columbus, OH, 2008), 21-36; J. Gregory, 'Eccentric Biography and the Victorians', *Biography*, 30, 3 (2007), 342-76.
[427] G. Debord, *Society of the Spectacle* (Detroit, 2nd. ed., 1977), 7.
[428] I return to the term "gaze" in chapter III, since it has specific connotations in the historiography of early-modern medicine. Here I just mean something like intense fixed staring.
[429] A. Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants: A Critical Biography and the* Memoirs of the Celebrated Dwarf Joseph Boruwlaski (trans D. Sax, Farnham and Burlington, 2012), 30.

copy.[430] Other compendia – like Thomas Frye's "Fanciful Heads" series (1760-2) or James Caulfield's *Remarkable Persons* (1813-20) – encouraged people to look at portraits of unusual bodies.

Portraits could purposefully cast curiosities as display-objects. Two engravings portrayed Francis Trouille, a horned man, from different positions, providing viewers with different vantage points and literally multiplying his status as something to gaze on (Figures 55 and 56).[431] Monstrous births and conjoined twins were two other curiosities that were often 'drawn-up'.[432] Sir Hans Sloane once sent a draughtsman to make portraits of the conjoined Poro twins after they were exhibited in London in 1714.[433] The Royal Society often had portraits of "human curiosities" made, since Fellows thought portraits were a convenient mode of validating the knowledge that inspecting curiosities gave them (cf. chap. IV).[434]

Portraits even served as a direct means of advertising oneself as a curious display-object. Caulfield noted that the rope- and wire-dancer Mahomet Caratha's "reputation was not diminished by the publication of his portrait."[435] Indeed, portraits openly referenced practices of curious looking that would cast their sitters as objects of display. The title of a portrait of *J. Kleyser; Born without Hands or Arms*... reminded viewers that he was ...*exhibited in London 1718*.[436] Meanwhile, the title of Capt. Baillie's portrait of James Turner, a beggar, reminded viewers that Turner *valued his Time at a shill*g *an hour* (Figure 57).[437]

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[430] P. Semonin, 'Monsters in the Marketplace: The Exhibition of Human Oddities in Early Modern England', in R. G. Thomson (ed.), *Freakery: Cultural Spectators of the Extraordinary Body* (New York and London, 1996), 69-81, at 70-1.
[431] WL 1920i.
[432] Hagner, 'Enlightened Monsters', 175; Stafford, *Body Criticism*, 272-3 (on Goya's *Los Capichos*).
[433] B. Telfer, E. Shepley and C. Reeves (eds.), *Re-framing disability: portraits from the Royal College of Physicians* (London, 2011). Other practices of display were also used by the Royal Society: in 1734, the society received the embalmed bodies of a set of triplets because they "are thought worthy of a place among the Human Curiosities." J. Zigarovich, 'Preserved Remains: Embalming Practices in Eighteenth-Century England', *Eighteenth-century Life*, 33, 3 (2009), 65-104, at 92.
[434] J. H. Appleby, 'Human Curiosities and the Royal Society, 1699-1751', *Notes and Records of the Royal Society*, 50 (1996), 13-27; Da Costa, *The Singular and the Making of Knowledge*, 14.
[435] Caulfield, *Remarkable Persons*, 140.
[436] WL 848i.
[437] WL 1923i.

As well as contributing to curious looking practices, portraits also contributed to curious and physiognomic classification processes. Caulfield's collection of remarkable persons' portraits was specifically of James Granger's "persons of the lowest description".[438] The book is full of Caulfield's explanations of how their portraits reveal (or do not reveal) their lowly-esteemed characters, i.e. how one can extrapolate character from appearance. It included people like Layton Smith whose "singularity of appearance and character gave rise to John Faber's engraving...."[439] Portraits often invited comparisons, which were pivotal to physiognomic method. Take the example of a giant "born near Cuckfield...in 1724....measuring 7 feet 4 inches, [who] exceeds the famous Mynheer Cayanus who was shown with so much applause several years ago".[440] The portrait of this giant not only compared him with – nay, classified him in relation to – another curiosity, but actually portrayed him being observed by four gentlemen in a drawing room *as* an exhibit. This sort of prompting of the viewer may also have been achieved by the "curiously" tag, an adverb that connoted careful artistic skill as well as inquisitiveness.[441]

Viewing portraits was one prominent way of responding to unusual bodies. Precisely how one ought to respond to bodily irregularity was the subject of much contemporary discussion. Excessive disagreeableness warranted disgust, contempt or fear – mainly because it was deemed to violate the theory that man was made in God's image.[442]The ridiculous warranted amusement.[443] The 'naturally' unfortunate warranted pity.[444] Fanny Burney's recollection of meeting someone with an unfortunately-sized nose

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438 Caulfield, *Remarkable Persons*, preface.
439 Caulfield, *Remarkable Persons*, 168
440 WL 170i, 171i.
441 OED: "curiosity".
442 Daston and Park, *Wonders and the Order of Nature*, cit. R. Lund, 'Laughing at Cripples: Ridicule, Deformity and the Argument from Design', *Eighteenth-Century Studies*, 39, 1 (2005), 91-114, at 94; cf. Stafford, *Body Criticism*, 319.
443 Stafford, *Body Criticism*, 181-2; Lund, 'Laughing at Cripples', 92; Ridiculousness was one of definition of deformity in Johnson's *Dictionary*; cf. below.
444 E.g., W. Whitehead, *On Ridicule* (London, 1743), 13. Whitehead's views tally closely with those of William Hay (see below).

captures the delicate balance of feelings and impulses experienced on encountering a curiosity:

> Mr Webb...has a nose, from some strange calamity, of so enormous a size that it covers the middle of his face. I never saw so frightful a deformity. Mrs Delaney told the Queen I had...been quite startled by him. ... Said her majesty... "When first Mr Webb was to come...I desired her to remember this was a misfortune, for which he ought to be pitied, and that she must be sure not to laugh at it, nor stare at it." ... The King added, "Poor Mr Webb...tried to hide his nose, by a great nosegay...but really that had so odd a look, that it was worse, and more ridiculous than his nose".[445]

What was most ridiculous was to try to cover up what was obvious.[446] Affectation and pretence called for most mockery.

The cultural forces of bodily 'suggestiveness' and the cultural practices of bodily inspection suggest reasons why artists would paint around temporary bodily aberrances – including 'passionate' states, pains and illnesses. If visual media could be construed in ways that would cast people as better or worse characters, then it follows that a lot hinged on appearance. Blending positive symbols with a 'good' likeness was more likely to cast a sitter in a positive light. As alluded to earlier in discussing Selina Hastings, contemporary theory prescribed that good likenesses should capture permanent states of being.[447] Jonathan Richardson, a firm believer in portraiture's ability to project general character, once painted William Henry, Prince of Orange "a little too robust...on purpose as the Pr[ince] was just recovered from an illness".[448] Whatever the prince looked like when Richardson came to draw him, it was not fit for a lasting frame. The prince's appearance either risked being out

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445 Burney, *Diary and Letters of Madame d'Arblay*, i, 392.
446 With this, cf. Lund, 'Laughing at Cripples', 105-8.
447 On Lessing, see Stafford, *Body Criticism*, 179.
448 Richardson, *Theory of Painting*, 80; C. Gibson-Wood, 'Jonathan Richardson as a Draftsman', *Master Drawings*, 32, 3 (1994), 203-229, at 214-5.

of keeping with his general (i.e., permanent) character, or it risked opening up the prince's (ill) likeness to character slurs. Samuel Johnson may have felt the same pressures when – in his own punning take on permanence – he railed against Joshua Reynolds' portrait of him with eye defects as "Blinking Sam".

Deformity

We have sketched how the interest in bodily difference and suggestiveness involved theorising about the body and developing certain practices of looking, both of which involved art. This leads us to our second malady: deformity. Deformity is very salient to the issues of this chapter for a number of reasons. First, deformity was inextricably tied to beauty. And as Veronica Kelly and Dorothea von Mücke have argued, eighteenth-century understandings of beauty derived from theories of and responses to visible, physical, bodily ugliness.[449] Second, the role of art in theorising about deformed bodies and developing ways of looking at them was particularly pronounced. In this section, therefore, I consider how portraits managed the representation of supposedly deformed sitters.

Definitions

Deformity, as Ephraim Chambers put it in his 1728 *Cyclopaedia*, referred to any deficiency, excess, or wants of proportion and uniformity in the body or personality.[450] These could be physical – like having extra body parts or being dwarfish. Or they could be mental, like exhibiting 'dullness' or manias. Deformity was mainly brought about by imbalances. It was

[449] Kelly and von Mücke, 'Introduction', 16.
[450] See D. M. Turner, 'Introduction; Approaching anomalous bodies', in D. M. Turner and K. Stagg (eds.), *Social Histories of Disability and Deformity: Bodies, Images and Experiences* (London, 2006), 1-16, 1ff; Lund, 'Laughing at Cripples', 95.

therefore characterised as a state of ill-health. Indeed, it had the same causes as other diseases. As Lord Shaftesbury held in his *Characteristics of Men* (1711):

> Natural health is the just proportion...of things in a constitution...And when the harmony of the rising pulses, the circulating humours...are disturbed or lost, deformity enters... [And] the same features which make deformity create incommodiousness and disease.[451]

As just mentioned, deficiencies, excesses and wants of proportion were deviations from the standards of beauty. Contemporary ideals of beauty were mainly inspired by the sculpture of the ancients. Theorists like Shaftesbury, Roger de Piles and Johann Winckelmann all asserted the beauty of simple, uniform, harmonious, proportional Greek sculpture – typified by the Belvedere *Apollo*, for instance. Such formulations of deformity were extremely durable in Britain. Two of Dr Johnson's *Dictionary*'s (1755) definitions were "ugliness" and "irregularity" – i.e. the opposites of beautiful regularity. The 1771 *Encyclopaedia Britannica* described deformity as "that want of uniformity necessary to beauty". Hogarth's championing of the beauty of the curved line in his *Analysis of Beauty* (1753) did not really overturn the classical model.

Beauty was, unsurprisingly, a rarely-attained ideal. The painter Alexander Cozens declared that the "beautiful face" was one impossibly "unmixed with character" – i.e. lacking the sorts of naturally occurring "deviations" that Grose spoke of (see above).[452] John Oldmixton, meanwhile, remarked in his *Essay on Criticism* (1728) that "a wen or mole on the face is sooner perceived than the harmony of features"; so a single taint could spoil the whole form.[453] Of course, in a commercial emblematic culture, make-up was readily available to try to put on the ideal complexion of "matte alabaster or lily with a hint of

[451] Cit. Lund, 'Laughing at Cripples', 97-8.
[452] Cit. Wahrman, *Making of the Modern Self*, 295.
[453] Cit. Stafford, *Body Criticism*, 82.

rose" that would erase all deviations.[454] And fashions like the *mouche* – small pieces of black fabric affixed to the skin to emphasise the surrounding whiteness – also developed in order to close the gap between expected and achievable beauty.[455]

Deformed bodies, deformed characters

As Cozens' and Oldmixton's remarks make clear, principles of beauty were often expressed through the body. Indeed, Barbara Stafford has argued that "the body was intimately tied to the establishment and upholding of ethical norms for ugliness and beauty."[456] Yet beauty was an ideal – an idea based on mental representations of the body. As Joseph Addison put it, it was "the Mind...[that] pronounces at first Sight Beautiful or Deformed."[457] It was not so much ugly material bodies that disclosed deformity, but rather what such ugliness signified in the mind's eye. This was character. Hermeneutically speaking, a deformed character was the signified of the signifying body. Any departure from beauty could therefore affect the assessment of one's character.

So what counted as deformed bodies and characters in the eighteenth century? What did the departure from beauty actually look like? The first answer is giants and dwarfs. Small bodies implied childish (literally immature) characters, while big bodies implied wild, savage characters. Dwarfs were accordingly treated as child-like playthings (see below). Monarchs kept dwarfs like Jeffrey Hudson and Nicolas Ferry much as they did fools and jesters.[458] Many had their portraits taken as curiosities.[459] Importantly, people

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[454] N. Andry de Boisregard, *Orthopaedia, or the Art of Correcting and Preventing Deformities in Children* (London, 2 vols.., 1743), ii, 208-10.

[455] Cf. C. Palmer, 'Brazen Cheek: Face-Painters in Late Eighteenth-Century England', *Oxford Art Journal*, 31, 2 (2008), 195-213, at 199-200.

[456] Stafford, *Body Criticism*, 16. See also Nussbaum, *Limits of the Human*, 54.

[457] Cit. Lund, 'Laughing at Cripples', 96.

[458] P. Grace, 'A wax miniature of Joseph Boruwlaski', *Metropolitan Museum Journal*, 15 (1981), 175-82, at 175.

[459] Examples include Velázquez's portraits of dwarfs at the court of Philip IV (c.1637-56) and van Dyck's portrait of Hudson (c.1633). Portraits of Hudson were still being displayed in St. James's Palace when Horace Walpole visited; H. Walpole, 'Journal of Visits to Country Seats' (ed. P. J. Toynbee, *Walpole Society*, 16, (1927-

worried about being portrayed as either too big or too small. Lady Wentworth, writing to her husband in 1711, complained of Charles Jervas' portraits of the couple that he "has made a dwarf of you and a giant of me...they are none of them like".[460] Her remark betrays the connotations for character that a skewed likeness would engender (especially when we recall that likeness need not have implied an absolutely faithful appearance). Indeed, Wentworth insisted that Jervas amend the portraits, which he did.

The second answer is "superabundantly" deformed bodies. These had growths or over-sized features and were often the subject of medical attention.[461] One example of how the judgment of such growths depended on the viewer's mind is the case of Charles de Saint-Evremond, a Parisian exile in London. A wen developed on his nose, which, according to his literary editor Pierre Silvestre, "grew to a good size, but...did not disfigure him very much, *at least in the eyes of those who saw him habitually*" (see Figure 58).[462] One could clearly get used to seeing a disfigurement and judging it kindly.

A third answer to the deformed body question would be crooked and misshapen bodies, mainly caused by spinal curvature or malformed limbs. The twisting of the body was thought to match a twisting of the soul and even to betray diabolical tendencies.[463] Trusses and stays were developed to help people straighten their backs and keep their legs upright.[464] William Wilberforce confessed to needing "a steel girdle cased in leather" to right his spinal crookedness (a problem evident in his unfinished portrait by Sir Thomas Lawrence).[465] Lord Byron bought a prosthetic foot to hide his club foot.[466] Wounded soldiers also sought prostheses.[467] Other examples of bodily deformity included squinting,

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8), 9-80), 15. See also J. Battin, 'Art and the history of medicine; the dwarf painted by Mantegna of Mantua and the Morgante of Florence', *Vesalius*, 15, 1 (2009), 5-8.

[460] Cit. Pears, *Discovery of Painting*, 143.

[461] Stafford, *Body Criticism*, 260.

[462] Cit. Ingamells, *Later Stuart Portraits*, 243. Emphasis added.

[463] This was Francis Bacon's formulation.

[464] The most successful of these manufacturers was Philip Jones. See P. Jones, *An Essay on Crookedness, or distortions of the Spine; shewing the insufficiency of a variety of modes made use of for relief in these cases* (1788), esp. viii.

[465] Simon, 'Disability'.

[466] Youngquist, *Monstrosities*, 164ff.

[467] Youngquist, *Monstrosities*, ch. 7.

excessive body hair and – following Nicolas Andry's list – pockmarks (see chap. I), red hair, slouches and vocal irregularities (high voices for men, low voices for women).[468]

Portraying good character

Given the negative assumptions about character that deformity could provoke, given that 'representations' were the means of perceiving deformity, and given the insistence on portraits being testaments to permanent character, it follows that people would not wish to be represented with their deformity – assuming they had a choice in the matter. Barring some caveats, which I shall come to, this is generally true – as the examples of William, Prince of Orange and Dr Johnson imply. Indeed, against this unforgiving context, simply having a conventional portrait taken at all might itself have stood as an assertion of good character.[469]

There were, however, one or two mental and behavioural faculties that could (at least partly) compensate for a warped body. These included virtue, honesty, gentlemanliness, wit and learning.[470] It is worth bearing these things in mind as we come now to our case-studies – for portraits related to these positive traits, too.

Having earlier described how portraits could associate people to melancholy, I wish now to describe how portraits could relate people to deformity – but in both an associative and dissociative capacity, depending on the sitter. The same principles were at work for deformity as for melancholy: portraits were deemed to be flexible tools, even figurative tools, with which to construct health-related identity. They were flexible according to 1) how the sitter felt about being deformed, 2) what he wished his portraiture to 'claim' about his supposedly deformed character, and 3) which features of portraiture he drew on to

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[468] See Andry, *Orthodpaedia*, i, 157. For more on this paragraph generally, see H. C. Covey, *Social Perceptions of People with Disabilities in History* (Springfield, 1998).

[469] I mean our notion of normality: respecting the form of the body and mind, the term was not contemporary; OED: "normal".

[470] On Bacon on virtue, see Todd, *Imagining Monsters*, 228.

express it. I also demonstrate that part of their flexibility lay in being used side-by-side with texts, be they poems, essays or memoirs.

Alexander Pope: upright portraits bespeaking an upright character

Alexander Pope was, as already explained, a pre-eminent poet and thinker. He was most celebrated for his translations of Homer's epics, his own mock-heroic *The Rape of the Lock* (1712-17) and the satirical epic *The Dunciad* (1728-9, 1742-3). His sharp wit earned him wide renown, but also got him embroiled in literary spats. So prized was his verse that many glittering figures of his age bade Pope to write their epitaphs, including, most famously, Sir Isaac Newton. Pope was undoubtedly a celebrity figure himself. Both his name and his face were well known. He ranks alongside royalty and the actor David Garrick as one of the most portrayed people of the long eighteenth century. During his time in Britain, Voltaire saw at least twenty print portraits of Pope above his hosts' fireplaces.[471] No better example exists of the recognition and popularity of Pope's portraits than the story of how hundreds of people worried when they thought that a portrait of (Roman Catholic) Pope owned by Lord Mansfield had been damaged in the (anti-Roman Catholic) Gordon Riots of 1780.[472]

For all his fame and success, Pope was an ill man. In childhood, he contracted tuberculosis of the bone – later called Pott's disease. It stunted his growth and gave him a hunch that he carried all his life. The literary giant was a physical dwarf. Pope once even referred to himself as a spindly spider and to his life as "this long disease".[473] His friend William Wycherley put it aptly when he said of Pope that "the sword gleamed bright in [its] decaying scabbard."[474] Pope's recent biographer, Maynard Mack, has gone so far as to say

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[471] H. Deutsch, *Resemblance and Disgrace: Alexander Pope and the Deformation of Culture* (Cambridge, MA and London, 1996), 19.
[472] See NPG D18867 and Burney, *Diary and Letters of Madame d'Arblay*, v, 99.
[473] Wimsatt, *Portraits of Alexander Pope*, xxiv; M. Nicolson and G. S. Rousseau, *"This Long Disease, My Life": Alexander Pope and the Sciences* (Princeton, 1968).
[474] Cit. M. Mack, *Alexander Pope: A Life* (New Haven and London, 1985), 158.

that when Pope became famous as a poet, he was already firmly established in the public imagination as a dwarf.[475]

Contemporaries recognised Pope's body to be deformed in certain ways. Joshua Reynolds, for instance, described him in 1742 as having a mouth that "had those peculiar marks which always are found in the mouths of crooked persons"; indeed, from them people could have "known him to be deformed".[476] Reynolds made no link between character and countenance, but others were not so generous. Ned Ward called him "A Frightful, indigested Lump, / With here a hollow, there a Hump".[477] His body was rough, bumpy and half-formed – all of which denoted the spoliation of a smooth perfect character.[478] Many people – often his literary adversaries – concluded that his outward deformity concealed a warped mind and being. Lord Hervey called Pope's body "A Symbol and a Warning to Mankind...of the Monster to be found within", while John Dennis said that "his Form is the best Index of his Mind".[479] On occasion, his critics rounded on Pope's portraits to make their point. Rysbrack's bust came under particularly fierce attack. In a 1729 satire punningly titled *Pope Alexander's Supremacy and Infallibility Examin'd*, there is a letter 'To REISBRACK, on his casting A. Pope's Busto', which reads:

> REISBRACK, no longer let thy Art be shown
> In forming Monsters from the Parian stone...
> There carve a Pert, not yet a Rueful Face,
> Half-man, half Monkey, own'd by neither Race.[480]

[475] Mack, *Alexander Pope*, 153.
[476] Cit. Deutsch, 'The "Truest Copies" and the "Mean Original"', 20.
[477] Cit. Lund, 'Laughing at Cripples', 100.
[478] See Lund, 'Laughing at Cripples', 100.
[479] Cit. Lund, 'Laughing at Cripples', 101.
[480] Cit. Wimsatt, *Portraits of Alexander Pope*, 101. On the monkey as an image of deceit and foolishness, see A. Maerker, 'The tale of the hermaphrodite monkey: classification, state interests and natural historical expertise between museum and court, 1791-4', *British Journal for the History of Science*, 39, 1 (2006), 29-47, at 37, 45.

Caricaturists exploited his deformed figure mercilessly. As his publisher Elijah Fenton remarked, the literary war mounted against Pope was waged "furiously in pictures and libels."[481] Some of these pictures drew on the monkey theme.[482] In *The Stage Mutiny* (1733), Pope was shown as a monkey holding a flag that reads "I am a gentleman".[483] Hogarth also crowned the simian Pope with a tiara in his *Distress'd Poet* (1737).[484] The monkey theme was picked up by yet another couple of satires, *Fronti Fides* (1729) and *His Holiness and his Prime Minister* (1729), identical in their portrayal of Pope (Figure 59). Pope's half-rat, half-monkey body stands on a pedestal. Pope's head is taken from Kneller's 1722 likeness (the same that hung over Curll's shop, the same that he used to assert his melancholy). It is crudely attached to the animal body like a modern-day photo-shop pasting; but it maintains the contemplative head-on-hand pose of the original, so heightening the bathos of the satire.[485]

Other satires were not so figurative, but quite blatant. One cast Pope as a small child. His diminutive figure is shown being carried like a naughty child by a taller man (Figure 60). Pope's legs kick out awkwardly. He appears bent over, which exaggerates his hump.[486] Another, an anonymous skit on Pope's and Swift's respective *Miscellanies*, depicts Pope as being so small that he has to stand on a table to reach Swift's head. A diminutive jester lurks in the foreground claiming "I'm also a poet".[487] These satires encouraged the viewer to look on Pope as an immature being of petulant character.

Scholars have shown that Pope's literary oeuvre conceptualised his deformity to rebut his satirists and to cast him as a virtuous, honest and morally decent man.[488] Scholars

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[481] E. Fenton to W. Broome, 24th June, 1729, *Correspondence of Alexander Pope*, iii, 37.
[482] E.g., BM Satires 2026.
[483] BM Satires 1937.
[484] J. Riely and W. K. Wimsatt, 'A Supplement to The Portraits of Alexander Pope', in R. Wellek and A. Ribeiro (eds.), *Evidence in Literary Scholarship: Essays in Memory of James Marshall Osborn* (Oxford, 1979), 125-64, at 164.
[485] BM Satires 1812.
[486] BM Satires 1935.
[487] NPG D27575.
[488] Todd, *Imagining Monsters*, 259, 256; Deutsch, *Resemblance and Disgrace*, esp. 32ff.

have also asserted that Pope's iconography was all to do with projecting a certain body image.[489] Indeed, Emma Clery has said that his portraits constituted a "deliberately mounted campaign" to alter his public image.[490] But barring a couple of comments – 1) from Clery herself about Pope's profiles and the focus on his nose, and 2) from John Kerslake about the perspective of Pope's legs in his portrait taken with Martha Blount – there has been scant analysis of how this actually happened by, in and through portraits.[491]

How are Pope's portraits a part of the history of deformity? I argue that Pope used portraits to dissociate himself from deformity in three ways. The first relates to the satires' repeated display of his hunch. Pope simply avoided, where possible, letting himself be portrayed in poses that showed his hunch; he only allowed it to be shown in circumstances that would deflect attention from the shape of his back. The second method is by his portraits' claiming him to be a man of virtue, which, as mentioned earlier, could salvage one's character. The third is by associating Pope to Apollo: this not only identified Pope as a poet blessed by the gods, but also related his form to Apollo's ideal beauty.

The first method is best revealed in the context of his whole iconography. Whereas his satires almost always depict him in full-length, Pope permitted no full-length standing portraits to be made in his lifetime.[492] He allowed no-one to capture his hunch or his awkward stance. Indeed, he took pains to ensure that it was never depicted. Referring to William Hoare's oil painting of Pope, Hoare's son, Prince, recollected to Joseph Farington that when Pope sat to his father

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[489] E. J. Clery, "'To dazzle let the vain design": Alexander Pope's Portrait Gallery; or, the Impossibility of Brilliant Women' – forthcoming, 5. I am grateful to Dr. Clery for sharing this paper with me. Cf. D. Piper, *The Image of the Poet: British Poets and their Portraits* (Oxford, 1982), 58; Mack, *Alexander Pope*, 660-2.
[490] Clery, "'To dazzle let the vain design'", 5.
[491] Clery, "'To dazzle let the vain design'", 11; Kerslake, *Early Georgian Portraits*, 212.
[492] For the satires calculation, see Deutsch, 'The "Truest Copies" and the "Mean Original"', 18.

> he showed an anxiety to conceal the deformity of his Person, & had a cloak thrown over his shoulders, & while Mr Hoare was painting that part of the picture, He came behind Him & said 'He need not be very particular about the shoulders'.[493]

Pope was anxious lest his deformed form appear on canvas. This portrait differs markedly from Lady Burlington's *impromptu* portrait of Pope playing cards, taken literally behind his back, in which his shoulders are plainly hunched.[494]

Pope's reluctance to display his deformities is also evinced by the fact that there are only two full-length standing *ad vivum* portraits: William Kent's pen-and-wash sketch of Pope in his grotto and William Hoare's red chalk sketch that was also done, as Hoare inscribed, "without ... [Pope's] knowledge". People realised that Pope would never have sanctioned Hoare to make such a sketch. Joseph Warton used a reproduction of Hoare's sketch as the frontispiece to his 1797 edition of Pope's *Works*. And he remarked of it (a little erroneously to begin with):

> This is the only Portrait that was ever drawn of Mr. POPE at full Length. It was done without his knowledge, as he was deeply engaged in conversation with Mr. ALLEN...by Mr. Hoare...Pope would never have forgiven the Painter had he known it – He was too sensible of the Deformity of his Person to allow the whole of it to be represented. – This drawing is therefore exceeding valuable...[495]

On the only other occasion when Pope was shown in full length, he was seated, crossing his legs, in a pose which naturally contorts the back.[496] The point here is that Pope never

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[493] J. Farington, *The diary of Joseph Farington*http://www.archive.org/stream/faringtondiary01fariuoft#page/n7/mode/2up, accessed 29th October, 2012, 190.
[494] Wimsatt, *Portraits of Alexander Pope*, 311.
[495] Cit. Deutsch, 'The "Truest Copies" and the "Mean Original"', 21.
[496] Only after Pope's death did John Cheere fashion, in 1749, a small lead statuette of Pope standing fully erect: Piper, *Image of the Poet*, 90.

sanctioned an artist to portray his likeness in a way that would have required an upright pose and therefore have exposed his stature.

The vast majority of Pope's portraits are heads-and-shoulders, busts, or profiles. Although Pope rarely commented on his portraits, and so we have to infer carefully, I argue that this pattern is not coincidental. There are many possible explanations for it. Clery suggested that profiles emphasised his 'manly' nose.[497] Another suggestion is that it was fitting for a poet inspired by the ancients to emulate their preferred profile pose, especially when the head was adorned with laurels; many other similarly inspired poets adopted it.[498] It would also have made sense for Pope to be known by his head, the site of his intellect and esteem. We saw this with his melancholy portraits, and it is possible that having himself portrayed as a creative melancholic was in itself a denial of his deformity. Yet another reason for the preference is that profiles privilege the *os sublime*, the "high [upright] face" that was considered the defining distinction between man and beast (even monkey). Evidence from his verse suggests that Pope thought that character resided chiefly in the face. He once had his satirical mouthpiece Richardus Aristarchus[499] claim that the courage of true heroes resides in "every limb" whereas in the mock-hero, it is all collected in the face. We may infer that Pope actually thought the opposite to his satirical prop – i.e. that the face does indeed bear witness to men's character traits.[500] On this point, it is significant that Jonathan Richardson inscribed "ΕΥΤΟΣ ΕΚΕΙΝΟΣ [The very man]" on one of his profiles of Pope; this inscription further suggests that the face bore sole testimony to Pope's person-hood (Figure 61).

The second method of dissociating himself from deformity involved *associating* himself to virtue. Just as his (and others') verse alluded to Pope's virtue, so a number of

[497] Clery, "'To dazzle let the vain design'", 11.
[498] Cf. Piper, *Image of the Poet*.
[499] Aristarchus was Richard Bentley in real life – one of Pope's literary antagonists.
[500] A. Pope, *The Dunciad in Four Books* (ed. V. Rumbold, Harlow, 1999), 76-9.

portraits claimed virtue for him.[501] One of Paul Foudrinier's head-pieces to Pope's *Essay on Criticism* was inscribed with the motto "UNI AEQUUS VIRTUTI ATQ. EIUS AMICIS", or "To virtue only and her friends a friend" – pulled from Pope's oeuvre as a mark of the man.[502] An etching by J. Jameson after van Loo came presented with exactly the same motto.[503] A number of Jonathan Richardson's engravings put the same point. This inscription marked Pope out as a man who strove after virtue.

The third method of Pope's dissociation from deformity was his juxtaposition with Apollo. I wonder whether Pope's portraitists and engravers sought to undermine received definitions of beauty when they decorated their *Popes* with busts of Apollo, the *locus classicus* of beautiful uniformity. Apollo was of course the poet's muse, but no other poet's portraits were adorned with this motif in this period – not Shakespeare's, not Prior's, not Gray's and none of John Simon's 'Poets and Philosophers of England' series. Yet Apollo's bust appears on Dassier's 1743 bronze *Pope* literally opposite Pope's bust – as though they ought to be compared and found similar. Apollo is also shown in profile with a lyre on the line engraving by J. Stow after Pond that was featured in Bowyer's *Historic Gallery* in 1794 and that could be bought separately (Figure 62).[504] The portrait after Richardson in Thornbury's *Life of Turner* also features a laureate profile of Apollo in a round frame. Perhaps Pope was being aligned to Apollo both poetically and physically.[505] Certainly, Pope and his engravers and printers seem to have tried to question what Pope's figure – once again, specifically his face – meant for contemporary ideals of male beauty by allying their subject with the archetype of the beautiful male form.

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[501] On his verse, see e.g. the excerpt from Cicero at the beginning of *To Arbuthnot*: "virtue, through her own charms, should lead you to glory". Dennis Todd has also argued that Pope claims himself an heir of his parents' virtue: Todd, *Imagining Monsters*, 241-3.

[502] NPG Heinz Archive: sitter box – Pope.

[503] NPG Heinz Archive: sitter box – Pope.

[504] WL (uncatalogued). A free-standing example is in WL (uncatalogued but inscribed "JF 181312").

[505] G. W. Thornbury, *The Life of J. M. W. Turner, R.A., Founded on letters and papers furnished by his friends and fellow Academicians* (London, 13 vols.., 1862), vii, 57; ix, 49.

Pope scholars have argued that Pope happily and continually sent up contemporary standards of bodily judgment. He was even partial to poking fun at others' appearance. Yet he was keenly sensitive of his own portrayal as visibly irregular and as an example of curious deformity. Pope once bemoaned to his friend Swift: "I don't wonder, if people from all parts should flock to see me, after the Picture lately drawn of me by a very peculiar Painter in Ireland, who has made the finest Show-Board of me, in the world."[506] We also know he was bothered by satires. William Hay, who we'll meet in a moment, claimed that "even Mr. Pope was not invulnerable" to satires, "for when the Dunces...produced a Caricatura of his Figure...it is evident that this stung him far more than a better Answer".[507] Jonathan Richardson also remembered how

> One of Cibber's pamphlets came into the hands of Pope, who said, 'These things are my diversion'. They [the Richardsons] sat beside him while he perused it, and saw his features writhen with anguish.[508]

Assailed by warped images of his form, Pope envisaged portraiture as a counterattack. Portraits could dissociate him from such pictorial jibes about his appearance. This they did in three ways: first by showing his whole body only on certain occasions and in certain poses, but otherwise focussing on his top half; second by referring to virtue; and third by associating Pope – via his face – to Apollo, the paragon of male beauty.

William Hay: character and the insufficiency of portraiture

As Mack said, Pope became known as a celebrated hunchback. As we just read, one person who commented on Pope's curved spine was fellow sufferer William Hay. Starting out as

[506] Pope to Swift, 9th April, 1730, *Correspondence of Alexander Pope*, iii, 101.
[507] Hay, *Deformity*, 8.
[508] Cit. Wimsatt, *Portraits of Alexander Pope*, 143.

an aspiring lawyer and minor man of letters, Hay (1695-1755) became the MP for Seaford in Sussex following a judicious marriage within the prime minister's family. Despite some prominent campaigning on poor law reform, Hay is nonetheless best remembered for his 1754 essay *On Deformity*.

In it, Hay put up a spirited defence of hunchbacks. Inspired by Montaigne, the essay is candidly autobiographical, didactic and full of classical learning. It was to stand by itself as an expression of Hay's well-formed mind. Hay sought "to write of Deformity with Beauty: and by a finished Piece to attone [*sic*] for an ill-turned Person."[509] Contemporaries thought him worth his claim. Literary anecdotist John Nichols described it as a "masterpiece of humour, wit, ingenuity, elegant style, fancy, and good sense". It went through four editions in two years.[510]

The particular pertinence of the essay to this chapter is the fact that Hay envisioned a role for portraiture in his defence of himself and others. As well as revealing a great deal about contemporary attitudes toward deformity and how it may define – or may not have to define – one's character, Hay's treatise commented on what portraiture can contribute, and what it ought not to contribute, to character presentation. These comments allow us to compare his essay with what his portraits show.

From first to last, the gist of the essay is that men should be judged by the contents of their minds and souls, not by the outward look of their bodies. Indeed, Hay dedicated the essay "to the greatest beauty", immediately calling the category's standards of judgement into question. Although he accepted that "Bodily Deformity is visible to every Eye", he repeatedly wondered why men pay so much attention to the outward form, and then only certain parts of it.[511] "Is the Carcass the better part of the Man?" he asked.[512] He

[509] Hay, *Deformity*, 3.
[510] Cit. DNB. Cf. S. Taylor and C. Jones, 'William Hay, M.P. for Seaford', *Parliamentary History*, 29, s1 (2010), lxi-lxxxvii.
[511] Hay, *Deformity*, 2.
[512] Hay, *Deformity*, 6.

questioned why "a Man's Person, which is the Dress of his Soul, only is ridiculed, while the vicious Qualities of it escape [ridicule]."[513] And he declared that

> It is not easy to say why one Species of Deformity should be more ridiculous than another...why they [men] should back-bite me...to my Face, and not laugh at my Face itself for being harrowed by the Small-pox. It is a back in Alto Relievo that bears all the Ridicule, though one would think a prominent Belly a more reasonable Object of it; since the last is generally the Effect of Intemperance, and of Man's own Creation.[514]

Against such moral ill-logic, Hay asserted that education "is certainly the Stamp of a Man's Character", that the deformed must "obtain by a Course of Behaviour that Regard, which is paid to Beauty at first sight", and that "the Improvement of his Mind is his [man's] proper Province".[515]

In claiming these things, Hay, like Pope, leant on Francis Bacon's claim about how virtue can immunise one's character from deformity: Indeed, Hay quoted Bacon:

> There certainly is a Consent between the Body and the Mind; and where Nature erreth in the one, she ventureth in the other [...yet] the Stars of Natural Inclination are sometimes eclipsed by the Sun of Discipline and Virtue.[516]

For Hay, improving the mind, educating oneself and behaving decently will demonstrate Bacon's qualities. If a man will seek an "upright mind in a crooked body", and nurture a "sound and untainted heart", he will be raised to beauty – to the "highest beauty" no less.[517]

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513 Hay, *Deformity*, 39.
514 Hay, *Deformity*, 34-5.
515 Hay, *Deformity*, 10, 30, 28.
516 Hay, *Deformity*, 40-1.
517 Hay, *Deformity*, 3, 58. This "highest beauty" is possibly wisdom, which is acquired by exercising the mind; *ibid.*, 69.

As well as asserting these positive traits, Hay also wished to "confute" certain claims about the physical consequences of deformity. For instance, he rejected the link between deformity and life expectancy.[518] He rejected – "by my own Behaviour" – Bacon's assertion that the deformed want "Natural Affection".[519] And he disputed that deformed persons are necessarily scornful, malicious, deceitful and envious.[520]

Nevertheless, Hay recognised that, whether by the appearance of the body or by experiencing inner virtue, people judged others' characters. He drew a distinction between the response (to his deformity) of the "Gentleman" and the "Vulgar" or the "Mob". He could "scarce pass" the latter "without hearing some Affront" to him.[521] Hay went on to say that deformed persons were not powerless inert objects but could affect how they were perceived. They could dress simply and not try to cover up any physical defect, like Mr Webb did (see above, and cf. chap. I). Hay said of himself: "it would be monstrous in me to bestow any Ornament on a Person, which is incapable of it."[522] Deformed people could also avoid ridicule by avoiding flocking together. For when they did band together, "it doubles the Ridicule, because of the Similitude; as it does, when they are seen with very large Persons, because of the Contrast."[523]

Portraiture was another way in which people could influence the judgment of their appearance. Hay realised that a deformed physique put pressure on one's likeness. He recalled Agesilaus, king of Sparta, a paragon of moral and intellectual excellence, but who was short, lame "and [of] so despicable a Countenance" that it was "no wonder he was unwilling to be delivered down to Posterity under the Disadvantages of so uncompromising a Figure".[524]

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[518] Hay, *Deformity*, 22ff.
[519] Hay, *Deformity*, 6, 42ff.
[520] Hay, *Deformity*, 53ff.
[521] Hay, *Deformity*, 9, 36.
[522] Hay, *Deformity*, 61.
[523] Hay, *Deformity*, 14.
[524] Hay, *Deformity*, 38.

Hay conceived ways around this ethical quandary which could still project a positive character image. For one thing, a realistic portrait could signal a sitter's moral probity. As Hay said:

> When I sate for my Picture, some years ago, I insisted on being drawn as I am, and that the strong Marks of the Small-pox might appear in my Face, for I did not choose to colour over a Lye.[525]

For Hay, a portrait was a way of demonstrating honesty.[526] Moreover, a likeness which avoided flattery and "abusing" one's image could also quash any criticism of appearance before it was meted out.[527] Even imagining sitting for a portrait could demonstrate self-confidence and acceptance of one's appearance. These three things came together in a challenge that Hay set any reader who might have doubted how he looked:

> If anyone imagines, that a Print of me in the frontispiece of this Work would give him a clearer Idea of the Subject; I have no Objection, provided he will be at the Expense of ingraving. But for want of it, let him know that I am scarce five Feet high: that my Back was bent in my Mother's Womb: and that in person I resemble *Esop*, the Prince of Orange, Marshal Luxemburg, Lord Treasurer Salisbury, Scarron and, Mr Pope....[528]

Hay openly declared how comfortable he was with having his likeness taken. He would not shirk from how he came across, especially as his readers might have expected a frontispiece (cf. chap. I). In fact, so honestly did Hay want to convey his appearance that he compares his figure with past famous deformed figures, many of whose portraits were circulated and

[525] Hay, *Deformity*, 37.
[526] Cf. William Thompson in chap. I.
[527] On these points, see Hay, *Deformity*, 36-7.
[528] Hay, *Deformity*, 4.

recognised well into our period.[529] However, Hay disputes quite explicitly that a visual likeness would proffer any "clearer idea" of him. He seems to casts the potential viewer as distrusting, almost voyeuristic, perhaps idly curious. Part of his rhetorical strategy is to impugn the very rationale for wanting to look at a portrait for signs of character in the first place.[530]

All this begs questions of his portraits. Did Hay practise what he preached? Could people look on his portraits to test the point? The answers are: not really on both counts. Only 'two' portraits of Hay are extant. The 'first' appears in the frontispiece to his nephew's 1794 edition of Hay's *Works* (Figure 63). It is a stipple engraving by James Heath after an 'original' by Samuel Shelley. Shelley was one of Joshua Reynolds' most prolific copyists; and it is possible – if not probable – that Shelley simply copied the 'second' portrait of Hay at Glyndebourne, which is attributed to Reynolds.[531] (We know Reynolds painted, and Shelley copied, a portrait of Hay's son, Col. Thomas.)

The portrait of Hay attributed to Reynolds is a half-length (Figure 64). It depicts Hay in a powder wig, claret overcoat and white neck-scarf, looking off to his left, against an extremely dark background – all in all, a very conventional pose.[532] Hay's nose is blotchy and reddened. Contrary to what his essay promises, the portrait bears no evidence of Reynolds' having painted Hay's smallpox scars (certainly nothing akin to the examples discussed in chap. I). As for Hay's bodily deformity, again contrary to the essay, there is no indication of his stature. Only the suggestion of a slightly disproportionately large head gives any clues about the size of his body. In the round, this is a portrait of a man of the

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[529] For instance, at least two separate engravings of Robert Cecil, the "crooked-backed Earl" of Salisbury were published in Hay's lifetime: NPG D25762, D25759; while four separate engravings of William, Prince of Orange appeared in 1734 upon his marriage to Princess Anne, daughter of George II: NPG D4976, D17091, D32900, D32901.

[530] With this, cf. S. Pender, 'In the Bodyshop: Human Exhibition in Early Modern England', in Deutsch and Nussbaum (eds.), *Defects*, 95-126, esp. 116.

[531] This attribution is quite recent; it was formerly attributed to John Hoppner. I am extremely grateful to Gus Christie, the present owner of Glyndebourne, for allowing me to see this portrait.

[532] Mr. Christie's father informed me that the portrait was formerly hung over a drawing room fireplace, which may well have affected the background tone.

establishment, painted by an artist at the take-off point of his career, which was (to my knowledge) never intended to leave the confines of Glyndebourne.[533] It was never meant to be a public 'statement' of Hay's appearance in the way that a frontispiece would have been.

However, if there is no evidence of Hay's portraits' presenting an image that would overturn how his character might have been perceived, the point to remember is that Hay did not wish to overturn the perception of himself. In fact, portraiture for Hay was a particularly powerful symbol of a viewer's visual judgment. It relied on his readers' awareness of portraiture practices (sitting and engraving for instance) and how a portrait supposedly conferred a "clearer Idea" of its subject. But for Hay, the symbol is a means of asserting his overriding contempt for (literally superficial) character appraisals. Highlighting what his readers thought they could expect from a portrait was a way of stating that a portrait simply *cannot* show all there is to show, that portraits cannot be transparent documents of character. The challenge he set to his readers would, if taken up, only confirm how right he was about their prejudicial way of looking and the insufficiency of portraiture. A portrait simply would not give "any clearer Idea" of him at all. And neither would his actual portraits, if ever they were seen. Perhaps for different reasons, they, too, embodied his stance against the perspicacity of portraiture.

Josef Boruwlaski: heightening character through portraiture

Hay was not alone in writing autobiographically about what it was like to be deformed. The memoirs of 'Count' Josef Boruwlaski also elaborate on deformity. Boruwlaski's deformity was dwarfism. He grew to no more than three feet and two inches high. Boruwlaski (1739-1837) was born into the Polish petty nobility. In his twenties – with a height in inches not much greater than his age – he travelled around the salons and courts of Europe, ingratiating himself as one of the retinue of Madame Humiecka. He bumped into the

[533] Again, I am grateful to Mr. Christie's father for his description of its situation.

Count de Tressan, who wrote a (favourably) comparative article on Boruwlaski and Nicolas Ferry for Diderot's and d'Alembert's *Encyclopédie*.

In Paris, Boruwlaski met the British ambassador. On the promise of favourable introductions Boruwlaski travelled to Britain in 1782.[534] Initially, he moved in high circles, giving concerts to sustain his new lifestyle. His memoirs, which first appeared in 1788, attracted 419 (mainly aristocratic) subscribers.[535] Eventually, however, he was forced into touring the provinces and latterly into exhibiting himself by 'receiving company' – although his memoirs, as we shall see, did garner much interest and some money.[536] Gathering together monies from his performances and friends, he bought an annuity and settled comfortably in Durham till his death in 1837.

Boruwlaski and his memoirs have not passed unnoticed. Yet while I agree with existing interpretations of his memoirs, I claim that historians and biographers have failed to appreciate, or have simply misunderstood, the role that his portraits played alongside and within them. My basic argument is that, like Hay in theory and unlike Pope in practice, Boruwlaski's portraits made an evident issue of his height. Boruwlaski wished to show that he accepted his stature but that his gentility made it irrelevant. I also argue that, in order to fulfil this aim, his portraits complemented the changing tone and register of his memoirs.

Even before Boruwlaski set foot in Britain, and then once he arrived, he was a talked-about man. Opinions of him were quite delicately balanced. He aroused a lot of comment because he did not fit contemporary expectations. He was rather surprising: he demonstrated no imbecility, but rather intelligence; he was not immature, but composed; he was not awkward, but genial, in company. Contemporary commentators recognised that the combination of stature and manner could arouse confused and unexpected reactions.

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[534] For more on Boruwlaski's early adventures, see Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*.
[535] C. Hutton, 'A memoir of the celebrated dwarf, Joseph Boruwlaski', *Bentley's Miscellany*, xvii (1845), 240-9, at 247.
[536] Hutton admitted that receiving company amounted to exhibition, 'A memoir of the celebrated dwarf', 248.

Indeed, Boruwlaski is part of the history of deformity precisely because he was not deformed in all the ways people expected him to be. P. G. Patmore recalled that

> He [Boruwlaski] used to go...about the house like a playful child...Yet [in company he behaved] with the tone and manner of a perfect gentleman...Nor in fact was there anything about him to create a strange, much less an unpleasant feeling in the minds of others. It was like looking at an exquisite object of virtu...He was perfectly straight, upright, well-formed and proportionate; yet when standing on the ground his chin could scarcely have rested on a dining-table of the ordinary height.[537]

Patmore did not expect sensibility on that scale. One gets a similar sense of exploded expectations from the *London Magazine* correspondent who wrote of Boruwlaski that "he is well-proportioned and there is nothing shocking about him"; or from the *Morning Herald* correspondent who wrote that "his person and mind are complete models of elegance and refinement".[538] Abigail Roberts included Boruwlaski among her "remarkable works of nature" precisely because (parroting Tressan) "Nature has refused nothing but size to this amiable creature; for which she has made him ample amends by the beauties of his body and mind."[539] It shocked such commentators that there was nothing shocking about him. In fact, the surprising combination of his size and manner made Boruwlaski a potential object of curiosity. The 1797 *Encyclopaedia Britannica* cast him as "an object of curiosity really worth the attention of the philosopher, the man of taste and the anatomist."[540]

Boruwlaski's memoirs in many respects confirm and encourage this view of him as curiously deformed man of elegance. They play on the fact that his size rendered him deformed and curious but his manner and style rendered him polite. As he declared at the

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[537] Cit. B. M. Benedict, 'Displaying Difference: Curious Count Boruwlaski and the Staging of Class Identity', *Eighteenth-Century Life*, 30, 3 (2006), 78-106, at 84-5.
[538] Cit. Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*, 12.
[539] A. Roberts, *The Entertaining Medley, being a Collection of True Histories and Anecdotes for the Cottager's Fireside* (Dublin, 1826), 143.
[540] Cit. S. Webb, *In Search of the Little Count: Joseph Boruwlaski Durham Celebrity* (Durham, 2008), 17.

outset of the first edition of the memoirs in 1788: "it is uncommon to find reason and sentiment, with noble and delicate affections, in a man whom nature...could not make up, and who in size has the appearance of a child."[541] And he realised that his memoirs "can be interesting only to those...who are wont to look upon beings of my stature as upon abortive half-grown individuals...who may be curious to see one of them assimilate himself to creatures of a common size."[542] Boruwlaski not only asserts a mismatch between his childlike appearance and his allegedly mature sensibility, but also recognises that he is apt for curious looking.

The blending of the language of sensibility and curiosity points to their juxtaposition in his body and character. On the one hand, he is a "doll", an "animated toy" to whom people, especially women, are led "by curiosity".[543] But that does "not prevent [him] from experiencing the power of the passions".[544] Nor does it prevent "many persons, by whom...I was looked upon only as an object of mere curiosity ...[to seek] my conversation".[545] The tone of his memoirs ebbs and flows, as though it embodies the loose connection between his body and his character, which contemporary categories just cannot properly pin down. At times, Boruwlaski writes coolly and matter-of-factly. He notes calmly that the duke of Marlborough "wished to have one of my shoes, and place it in his cabinet among other rarities".[546] Here he unashamedly acknowledges his contribution to curiosity. At other points, however, he is plaintive and rueful: he laments the snubbing that reduced him to appearing in public.[547] And right at the end of his first memoir he bemoans the fact that "my stature has irrevocably excluded me from the common circle of society".[548]

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[541] J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious account of his birth, education, marriage, travels and voyages; written by himself* (trans. Des Carrieres, London, 1788), 2.
[542] Boruwlaski, *Memoirs of the celebrated dwarf*, 2.
[543] Boruwlaski, *Memoirs of the celebrated dwarf,* 30, 65-6.
[544] Boruwlaski, *Memoirs of the celebrated dwarf*, 43.
[545] Boruwlaski, *Memoirs of the celebrated dwarf*, 61.
[546] Boruwlaski, *Memoirs of the celebrated dwarf*, 235.
[547] Boruwlaski, *Memoirs of the celebrated dwarf*, 167.
[548] Boruwlaski, *Memoirs of the celebrated dwarf*, 247.

As Anna Grzeskowiak-Krwawicz and Barbara Benedict have noted, Boruwlaski acknowledged that his oddity was the main selling point of the first edition. That is why he wrote about it at such length. All that had changed by the final 1820 edition.[549] The 1820 title bore no mention of his dwarfism. By that time, he wished to be known only in his quasi-aristocratic guise of 'Count Boruwlaski' – only as a genteel man. As Benedict argues persuasively, his memoirs recount the "struggle to reshape the public identity accorded him by his status and stature into a self-definition stressing his sensibility, independence, and manners."[550] When he writes about his stature in 1820, the tone is more stoical than rueful. His memoirs, then, sought to create their own impression of Boruwlaski's character: by repudiating the link between body and mind and character, he showed that a potent and desirable character could be housed in a puny body.

Such is his 'textual' history. Yet Boruwlaski was not just written about and read: he was drawn and seen. I wish to show how his portraits complemented what his memoirs sought to do. Briefly summarised, I argue that his portraits did not shirk from showing how miniscule he was, or that he was a prime target for curious looking, but that they emphasised his genteel character by borrowing ways of making gentility visible. They re-appropriated (from satires) some of the tropes and devices with which he had been ridiculed.

There was a considerable public traffic of Boruwlaski images. Many of them appeared in publications that cast Boruwlaski as a curiosity. Abigail Roberts, for instance, included a cheap woodcut of him next to the 'Irish Giant' Charles Byrne and an ordinary sized man in her passage in *The Entertaining Medley*. Boruwlaski realised he and Byrne made a curious duo:

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549 Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*, 62; Benedict, 'Displaying Difference', 79, 99.
550 Benedict, 'Displaying Difference', 79.

> A short time after my arrival in London, there came also a stupendous giant...Many persons seemed desirous of seeing us together...Had a painter been present, the contrast of our figures might have suggested to him the idea of an interesting picture; for having come very near him, the better to shew the difference, it appeared that his knee was nearly upon a level with the top of my head.[551]

The idea was not lost on the curious. The same idea prompted John Kay to make an etching of Boruwlaski juxtaposed against Neil Fergusson (the tallest man in Edinburgh) for his eponymous *Edinburgh Portraits* (1802) (Figure 65).[552] Boruwlaski was included with portraits on his admission to the *Wonderful Museum* series,[553] and also when Henry Wilson included him among his *Wonderful Characters* (1822).[554] Finally, Boruwlaski was portrayed as one of the two main attractions of Bullock's Museum of Natural Curiosities in a satire by Thomas Rowlandson. He is represented next to Saartjie Baartman, a "Hottentot Venus", a touchstone of early-nineteenth-century curiosity.[555] The portraits used by Rowlandson both depict Boruwlaski and Baartman being stared at; both the portrait itself and its use in a satire point to Boruwlaski's status as a curiosity.

Other satires poked fun at his having to display himself. Another Rowlandson satire depicts Boruwlaski playing the violin in a harem, harking to his need to earn money from appearing in front of an audience. The fact that such 'performances' easily collapsed into outright exhibitions is alluded to by the enormous difference in size between Boruwlaski and the massive Turk and voluptuous women who listen to him: they are there and depicted so large simply because he is there and so small.[556] In another satire, Boruwlaski is depicted "taking an airing" – another play on his need to be seen in public

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[551] Boruwlaski, *Memoirs of the celebrated dwarf*, 199-201.
[552] J. Paterson, *Kay's Edinburgh Portraits; A Series of Anecdotal Biographies, chiefly of Scotsmen* (Edinburgh, 2 vols.., 1885), i, 326-9; WL176i.
[553] Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*, 55; Benedict, 'Displaying Difference', 81-2.
[554] Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*, 55.
[555] BM Satires 12702.
[556] BM Satires 7065.

(Figure 66). Boruwlaski is seated on his female carriage's over-sized petticoats, and is sheltered "from de rain" by the over-sized brim of her hat. His pose and her ridiculous costume send up his desire to mix with the fashionable and well-to-do.[557]

Another feature of Boruwlaski's attempted character presentation that prompted satirical attack was his (perceived) pretences to gentility. A pen and wash sketch by Edwin Landseer depicts Boruwlaski silhouetted in an over-sized coat. Composed quickly, with little deliberation and with quite some messiness, the image certainly jars with any image of grace and finery. The portrait is entitled just *Count Boruwlaski*, a possible poke at his use of the title in his later life.[558] A final example makes absolutely plain how pretentious certain people thought Boruwlaski was. A satire published among William Holland's "largest collection of Humorous Prints" depicts a dwarf as the judge of a political high-jump contest. The identification of the dwarf with Boruwlaski is made clear by the long description below the scene. His attempts to ingratiate himself among the higher echelons, and to display those attributes that would outweigh his deformity, are clinically and mercilessly rebuffed:

> The Sieur Jablanowski, just arrived from Lilliput...now offers his services to the Nobility and others who are desirous of distinguishing themselves at the illustrious Court of Utopia. – It has long been the mistaken notion at this Court, that Virtue, highly cultivated Understanding, Integrity and Honour, were the proper requisites for Gentlemen...The Sieur Jablanowski, therefore, undertakes to prove, that none of the above qualities are at all necessary, and that if Gentlemen Candidates are only endow'd with a moderate pliability of the back-bone! he will assure them...Pensions, Places and Preferments.[559]

[557] BM Satires 7220.
[558] NPG 3097(8).
[559] BM Satires 7554.

The satire clearly presents Boruwlaski as a false prophet, a pretender to cultivation, virtue and decency. It tries to reassert the incongruence or incompatibility of a crooked back-bone and the gentlemanly qualities that Boruwlaski has arrogated to himself.

Boruwlaski had no control over images like these. But he helped to generate many other portraits that signalled his challenge to the impressions wrought by satires. His 'authorised' portraits cropped up in a number of places – from frontispieces to public exhibitions. Overall, they mark him out to be a man comfortable with his height and a man who successfully assimilated to English genteel culture. To do so, they exploited a number of representational strategies and motifs.

A concerted challenge to the 'satirical view' was manifested in the frontispieces to his memoirs. The first edition's frontispiece, by William Hincks, portrayed Boruwlaski in "a Family-scene" (Figures 67 and 68). He reaches out to his daughter, who is held by his wife, Isalina. Boruwlaski holds out a little toy bird for his daughter to grasp. Beneath the portrait is the following inscription: "Mysterious Nature, who thy Works shall scan? / Behold a Child in Size, in Sense a Man". (The French inscription in the bilingual edition refers to his being about the size of a child of three or four years.) Indeed, the very scene and composition of the portrait, taken with the inscription(s), appear to be an ironic take both on the physical similarity between father and daughter and on his likening to a child or toy (see above).

Yet as well as it shows that Boruwlaski was happy not to take slurs about his stature too seriously, the frontispiece does insist on his mature sensibility. Specifically, the frontispiece signifies Boruwlaski's sensitivity as a family man. He is depicted as a playful father, doting and attached to his daughter. The physical difference of the (substantially bigger) mother only serves to reinforce the father-daughter connection. So does Isalina's pose: she appears almost detached from the father-daughter intimacy as she looks toward the viewer. The overall scene also activates the symbolic potential of the family-scene genre. Family portraits had for centuries been a powerful means of signalling one's self-

proposed gentility (see chap. I). Portraits of the family at leisure were a popular eighteenth-century modification of that tradition. Boruwlaski here places his own family squarely in it.[560] And lest only readers of his memoir be able to see him in that way, Boruwlaski had the frontispiece re-engraved for separate purchase. He was keen to multiply the image of him as a polite leisured doting family man.[561]

Another engaging feature of Boruwlaski's first frontispiece portrait is the ceremonial epée he wears. He can be seen wearing an epée in the frontispiece to the second edition, too (Figure 69). He sports it in a stylised, almost performative stance. As we have seen time and again, the accoutrements that people were portrayed with were not neutral 'things' but connotative symbols. As we saw in John Hunter's portrait by Reynolds, where Hunter is surrounded by objects that he wished to associate to the type of work he did, accoutrements became meaningful by how and where they were 'deployed' – i.e. how they were made visible. Boruwlaski did not have to be portrayed wearing a sword. Yet wearing it aligned him with countless aristocratic figures for whom a sword connoted prestigious armorial heritage (if not actual military service) as well as temporal power and riches.[562] In this sense, the pose and sword – the chiefly noticeable features of the portrait – sought to reinforce Boruwlaski's proclamation that he was a man who belonged to the (once) armorial classes. The same principle of material cultural association was at work in the engraving that Joseph Bouet made in 1833 of Boruwlaski sitting on a sofa holding a cane, another accoutrement synonymous with gentlemanliness.[563]

Anna Grzsekowiak-Krwawicz has claimed that Boruwlaski's figure in this second edition's frontispiece made an issue of his size and that the frontispiece to the final edition

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[560] See D. H. James, 'Not just child's play: adolescent boys and girls at leisure in eighteenth-century portraiture', paper presented at 'The Representation of Adolescence in Early-Modern Europe' conference, Cambridge, 24th September, 2010.
[561] E.g., WL178i.
[562] See e.g. Peter Lely, *Arthur Capel* (1653); Amoy Chinqua, *Joseph Collet* (1716); Sir Thomas Lawrence, *Charles William Vane-Stewart, 3rd marquess of Londonderry* (1812).
[563] Cf. W. MacMichael, *The Gold-headed cane* (London, 1828) for a strong allusion to its importance among physicians.

did not.[564] I argue the opposite. This allows me to tie in the portrait to the changing emphasis and tone of the final edition's text. The second edition pose portrays Boruwlaski in full length. Yet, *pace* Grzsekowiak-Krwawicz, there is only his leaning on the table that suggests how *relatively* tall he is. Besides this, only the title's and inscription's reference to his dwarfism gives any true indication of his size. In the final edition frontispiece, however, Boruwlaski is shown standing next to a woman who not only towers over him but who looks down on him, too (Figure 70). The woman is Isabella Downman, daughter of the artist John Downman, who took the dual portrait in 1812 on a tour of Northumberland.[565] The portrait is concerned with Boruwlaski's height inasmuch as Downman placed him obviously next to a considerably taller woman who by her pose recognises Boruwlaski to be unusually small and worthy of inspection.[566] Moreover, Boruwlaski is himself shown in an expressive pose, seemingly captured mid-conversation and not aware of the presence of the larger woman. Importantly, however, his finger points upwards, drawing the viewer's eyes to the vertical axis of the portrait – in other words gesturing the viewer to acknowledge the discrepancy between the sizes of the bodies portrayed. That Boruwlaski should have opted for this print in 1820 is in keeping with the changing tenor of the final edition itself. The portrait is as much of an (open if not cheerful) acceptance of his size as the text. It is also a riposte to those images that portrayed him with larger people in order to poke fun at his size, like those with Byrne and Fergusson.

If his frontispieces projected a certain view of Boruwlaski, then his formal stand-alone portraits did likewise. They evince the fact that Boruwlaski was keen to portray himself as a man of stunted growth but full mind. They, too, exploited compositional traits, the symbolic value of accoutrements etc.. Take Edmund Hastings' portrait of him that now

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[564] Grzeskowiak-Krwawicz, *Gulliver in the Land of Giants*, 62 [double check precise page!!!!]

[565] The original is in BM 1936,1116.30.26. Although the copy that appeared as the frontispiece is inscribed as by W. T. Fry after Downman, Fry actually followed Joseph Bouet's copy of Downman's original; Bouet's copy is in Durham University Library, Add. MSS 1300, 202A.

[566] Downman also bothered to inscribe Boruwlaski's height below the original drawing.

hangs in Durham Town Hall.[567] Little documentary evidence exists to elaborate on the context of its commission, but the portrait itself is full of clues about the projection of a public image. Importantly, the most obvious eye-catching features of the portrait do not relate to his height but his status. The small guitar on the table nods to his polite 'recitals'. The opulent furnishings suggest a comfortably wealthy man. The cane, hat and gloves imply his having been to some genteel gathering. And his pose is the crossed-legged, hand-in-waistcoat pose adopted by many gentlemen in this period.[568] Only secondarily does the viewer notice how disproportionately large the cane appears – especially as it runs parallel with the crossed left leg and as both the cane and the body lean on the side-table. Only secondarily does one notice the fact that his head barely reaches above the line of the table. The portrait conveys the very impression that Patmore noticed above: one of an elegant man whose head barely reaches an ordinary table. It is an impression that upsets the extrapolation of deformity from his body.

The portrait of Boruwlaski commissioned by John Hunter, the anatomist, is remarkably similar to Hastings' in these respects (Figure 71). Taken by Philip Reinagle in approximately 1794, it portrays Boruwlaski in full length.[569] He stands in a relaxed manner in a drawing room, with his right arm propped against the arm of a chair. The furnishings, including the hanging paintings, are equally as opulent as those shown in Hastings' portrait. Both portraits place Boruwlaski in domestic spaces wealthy enough to be adorned with fine art.[570] Boruwlaski's military uniform, complete with sword, aligns him with the armorial class in the same way that the second frontispiece would do a decade later. For all these allusions to his gentility, the portrait is nonetheless a study of his body's scale. The propping of Boruwlaski's arm on the chair is a conscious prompt to compare his body with

[567] I am grateful to Sheila Fox at Durham Town Hall for discussing its Boruwlaski collection.
[568] Cf. Meyer, 'Re-dressing classical statuary'.
[569] RCSE, RSCSC/P 248.
[570] In Hastings', only the luxurious frame is visible – though gilded frames could be as expensive as the paintings they house; J. Simon, *The Art of the Picture Frame: Artists, Patrons and the Framing of Portraits in Britain* (London, 1996).

furniture built for those of ordinary height. Yet the flight of stairs and the banister, visible through the open door in the background, also invite the viewer to consider height by a different perspective. Boruwlaski's body stands between the chair and the stairs in the viewer's eye-line. Yet it is only by the closer gauge of the chair that Boruwlaski's height appears extraordinary. As Boruwlaski's body leans on the chair, we realise that the portrait's very composition is posing questions about contemporary standards of bodily judgment. His body is placed between the two gauges of scale – which will the viewer adopt? A similar sort of 'scale question' was posed by the composition of Samuel Percy's 1798 miniature in which Boruwlaski's (literally) tiny waxen body unusually takes up only a small fraction of the (already) little oval frame (Figure 72).[571] Reinagle's portrait differs only in one major degree from Hastings': we know it was put on display in Hunter's Leicester Square museum. It went public.[572] Like Pope's actual portraits and Hay's symbolic references to portraiture, Boruwlaski's portraits were part of a dialogue about the impression of his body and contemporary practices of display and looking.

There is a striking similarity between the attitude of his memoirs and the suggestions of his portraiture. Both sought to present him as a genteel man. The memoirs did so by demonstrating his ease in the salon cultures of Europe and among Britain's elite. The portraits did so by opting for certain poses, settings, scenarios, accoutrements and even media. Both text and portraits also presented Boruwlaski as a man concerned with his stature and the judgment of his bodily deformity – but only insofar as he hoped to show his mind and gentility to be excellent enough to supersede them.[573]

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[571] See Grace, 'A wax miniature of Joseph Boruwlaski'.

[572] http://surgicat.rcseng.ac.uk/(S(rhfvd4455xlokpqzzdr4ij55))/detail.aspx?parentpriref=#; accessed 2nd October, 2012.

[573] Although, as mentioned above, it is slightly beyond the remit of the chapter to consider the point, there is some evidence that Boruwlaski succeeded – that the final historical records did present him as a man whose mind superseded his body. His obituaries tended to record his height but then focus on his superior character; meanwhile, just before he died, a full-length statue was cast of him standing as testimony to a polite gentlemanly musician.

Conclusions

The portraits of melancholics and of Pope, Hay and Boruwlaski all demonstrate further how illness could impinge on the expression of identity in the long eighteenth century. Eighteenth-century culture encouraged the extrapolation of character from the look of the body. Since portraits represented the body, it was fitting that they should be used as a prime way of expressing character and identity. Since health and illness were thought to be recognisable through the body, it was equally fitting that contemporaries devised ways for portraits to represent the effects wrought on the body and character by illness. Moreover, since satires were another prime means of representing the body, it was apt for portraits to contend with what satires showed. These processes culminated in contemporaries' exploiting portraiture's different media, styles, motifs and traditions to associate or dissociate sitters from certain conditions that had character connotations.

The choices of form, expression, pose, setting, accoutrement, inscription and the like – including the choices of what not to show – all constituted this active assertion or denial of character. Such artistic choices were not forced on the sitters by the artist or anyone else, but were rather compelled by specific 'character issues'. In the final analysis, I argue that the most convincing explanations for the look of these portraits recognise that these choices were made by sitters based on their own perceptions – both of the effect of illnesses on their character and of the possible inferences that their illness might draw. In the first case-study, the issue was how to represent an avid mind: melancholy was a condition of an avid mind and portraiture supplied the motifs of it. In the second case-study, the issue was how to contend with the implications of a deformed body: portraits supplied mechanisms of channelling attention away from it and/or on to other information about character.

In each case, portraits contributed to a dialogue that was generated – sometimes self-generated – about the sitter's character. On the one hand, these contributions could be

constructive or assertive, as in the case of melancholy: they could create the link between an illness and a character because the illness connoted positive character traits. On the other hand, a portrait's contribution could be destructive or denying: it could try to destroy the link between an illness and character because the illness connoted negative character traits. Either way, like William Thompson's mimicking of Job in chapter I, these portraits show how sitters thought *they* could and should determine how their illnesses and characters were thought of. If sitters had no control over the distribution and recognition of caricatures, then portraiture gave them a much greater power to determine how they would appear. They gladly exercised it. We have seen, for instance, how Alexander Pope kept a careful watch over the look of his portraits. The agency exerted in controlling the artistic choices of a portrait differs remarkably from the agency that historians have imputed to patients and sufferers until now. Their agency did not only concern their access to care or influence in doctor-patient relationships, but extended to articulating identity through representing illness.[574]

This agency was particularly powerful when a sitter realised how their portraits existed as social objects – as 'fronts' on show. To examine what sitters thought portraits could do in this respect, we paid attention to contexts like where they would be seen, how they would be seen, alongside what they would be seen, and what was thought about the sitter at the precise time they were seen. The way in which portraits relate to this data shows them to be social objects particularly flexible at transmitting information about a person and responding to what was already 'out there'.

The first two chapters have shown that portraits were powerful instruments to transmit and respond to information about illness and health. They mediated the facts and implications of being ill. Among the contemporaries most concerned with information about patients' illness and health and the facts of their being ill were doctors. The next

[574] Cf. Introduction.

chapter will consider how doctors, in making and using portraits of their patients, capitalised on portraits' ability to do just these things.

Chapter III – Portraits in medical transactions

Introduction

The previous two chapters have explored how portraits showed illnesses, how people looked at illness and how portraits actively managed the effect of illness on character and identity. There are further ways we can interrogate how portraits generated and managed patients' and sufferers' medical 'looks'. One way is to probe what portraits of patients and sufferers revealed and meant when they were made by specific medical people in specific medical circumstances. For doctors looked upon illness – not necessarily to judge character, but to diagnose, treat and deepen their medical understanding. Doctors were deeply interested in the way the body manifested signs of ill health. Moreover, they conceived of their patients' identity as ill people and as one party in a consciously medical relationship.

Focussing on specific medical practitioners and circumstances allows the thesis to put the evidence of portraiture to wider historical questions about early-modern medicine. How did doctors work? On what basis were relationships between doctors, patients and other groups formed and sustained? This narrower enquiry also opens the thesis up to ask wider questions about the role of art within early-modern medicine, in particular about its clinical functions and relationship-creating capabilities. How did portraits fit into doctors' working practices? What did they do in and for medical relationships? In this chapter, therefore, I explore how early-modern doctors made and used – or had made and used – portraits of their patients. And in the final chapter, I will consider portraits' place in early-modern medical relationships.

When I refer to "specific medical circumstances" for the purposes of this chapter, I mean to denote medical 'transactions' between patients and doctors. Portraits were often made when doctors got involved in helping a sufferer – i.e., when the sufferer became a

patient. Not every such 'transaction' entailed a portrait, but many did. I use the term 'transaction' for a number of reasons. Just like artist-sitter transactions that generate portraits (see Introduction), doctor-patient transactions sought to resolve their participants' interests. Whether treating by letter, by consultation, by operation or however, doctors had a job to do, and patients wanted to get better. Again as we read in the Introduction, these encounters were not always smooth. Besides the obvious interests of health and professional status, power, prestige and money were all at stake. Thinking about transactions brings the issues of agency and relationships to the fore. The other reasons for using the term 'transaction' are more historiographical. Much of the historical sociology of the medical profession has conceptualised doctor-patient dealings as mutually negotiated encounters. Such conceptualisations underlie the work even of scholars whose conclusions about patients' and doctors' role and influence in the transaction differ starkly.[575] Finally, the term 'transaction' also reminds us of the commercial nature of the medical marketplace from which patients could choose their help.[576]

Put most broadly, the chapter's main arguments are that doctors' portraits of patients combined the aesthetic and practical elements of showing and looking (cf. chap. I).This combination informed how doctors imagined the identity of their patients. I argue that doctors' portraits showed illnesses because they helped doctors to clarify, describe and generally make more sense of their cases. Indeed, portraits both described and analysed; they were both illustrative and explanatory. They also showed illnesses in order to serve as records of cases, to communicate about cases, and to inscribe knowledge about how diseases appeared.

Moreover, early-modern medical practice prescribed many ways of and reasons for looking at illnesses. Diagnostic inspections and clinical observations are two examples. These practices relied on skills, such as close inspection, that were equally possessed by

[575] Compare, for instance, the accounts of Nicholas Jewson and Michel Foucault: Jewson, 'The Disappearance of the Sick-Man'; Foucault, *The Birth of the Clinic*.
[576] Porter, *Health for Sale*; Gentilcore, *Medical Charlatanism*.

people who looked at art (especially the connoisseur).[577] As I will explain in more detail below, the anatomical 'modules' of a surgeon's training centred on art and honed skills that he would already have begun to acquire as an aspirant to polite society.

I accordingly argue that such modes of looking are inscribed in portraits. Different ways of showing and looking could make portraits 'look' like *patients' illnesses*. Different combinations of different modes of looking and showing made portraits more or less individualised. Sometimes, portraits were more about patients than about diseases. Sometimes, they were more about diseases. And sometimes they were about both patients and diseases.[578] Showing and looking impinge on a number of themes to do with the relationship of portraiture and medicine – like the notion of objectivity, for instance. These combinations, mutual influences, feedback loops and thematic 'pressure points' are further powerful incentives for analysing doctors' portraits of patients.

To pursue these arguments, I ask how and why doctors made and used such portraits. Historians could justify this query on the simple ground that they ought to account for the existence of a large number of primary sources. A subtler rationale, one that ties in with a thesis exploring the uses of portraits as evidence in medical history, is that the meaning(s) of images can be acquired. Meaning does not only consist of iconographic suggestions or what portraits might communicate. It can emerge from how they are used, where they are sited and re-sited, and how they sustain relationships once they have been made.[579] The 'use question' therefore penetrates what portraits did and how they became meaningful when used. In other words, this emergent meaning is a crucial component of the historical kinship between medical practice and portraiture.

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[577] See Pears, *Discovery of Painting*, 111.

[578] On the historiographical issues of reference and 'aboutness', see D. LaCapra, *Writing History, Writing Trauma* (Baltimore, 2001).

[579] L. J. Jordanova, 'Keith Brown memorial lecture. Medical portraiture: the case of William Harvey', *Liverpool Medical Institution Transactions and Report 2008-9* (Liverpool, 2010), 15-21; D. Lomas, 'Rivera Cardiology Murals', talk presented to King's College London, 10th September, 2010 (on citations of Vesalius in Mexico); Scott, 'Under the sign of Venus'; Carrier, 'Art Museums'; M. Pointon, 'Material Manoeuvres: Sarah Churchill, Duchess of Marlborough and the Power of Artefacts', *Art History*, 32, 3 (2009), 485-515.

Given that this chapter focuses on a single type of person, we might expect that the meanings of doctors' portraits of patients should relate to doctors' unique occupational status(es) – that is, what they did, what they knew, what they thought about portraits (as a means of 'record-keeping, for instance) and so on. These meanings can therefore be set against the meanings of portraits that derived from specific illnesses and types of patient (see chaps. I and II). One particularly telling point of comparison that this chapter allows, for instance, is portraits' relationship with text: do doctors' case notes interact with portraits in similar ways as poems on smallpox or treatises on deformity?

As in the last chapter, I pay attention to clues about how portraits came to be, as well as to what portraits themselves reveal. I treat portraits alongside clinical documentation and refuse to give automatic priority to textual deposits of medical transactions. I compare portraits in different types of medical practice, to try to encompass as many of those "unique occupational status(es)" as possible. Indeed, not to do this would be to reify medical practice. I have selected three case-studies that will let us compare similarities and differences, that suggest how doctors thought about portraits as evidence, and that might convey to the reader some sense of the sheer variety of patient portraiture and its deep penetration into long eighteenth-century medical practices.

The material spans broad medical disciplines (like general surgery) as well as more 'niche' sub-disciplines (like ballistic wounds). As might be guessed from this disciplinary variety, the material is not artistically homogeneous. The evidence ranges from small and rather dashed-off pen-and-ink sketches right up to detailed elaborate watercolour paintings. Different doctors comprehended the matter of taking a portrait differently. They also construed the implications of taking a portrait differently. Meanwhile, some doctors took portraits themselves, whereas others employed assistants or resident artists or relied on pupils. Ultimately, the quantity, variety and detail of portraits of patients can tell us as much about doctors as we have learnt from doctors' own portraits or even long-privileged textual sources, which have hitherto dominated historians accounts.

Using portraits of patients to explore the historical kinship between medicine and portraiture in practical medical settings has rarely been done. Emma Chambers' study of Henry Tonks' portraits of Harold Gillies' war-wounded patients stands proud as one of the few theorised studies of that kinship.[580] Maureen Park has recently examined the art produced *by* Thomas Browne's patients in the Crichton asylum; and although this includes portraits of (other) patients, Park's remit does not take into account the specific implications of the portrait genre.[581] Alan Emery has produced an account of the doctor-patient relationship in art; but it is rather whimsically concerned with medical progress.[582] Elsewhere, medics and historians of medicine have invoked the language of portraiture to examine medical practices, including the role of vision (see below),yet without paying explicit attention to the art itself.[583] Consequentially, historians have decidedly underplayed just how embedded portraiture was in medical practice.

However, scholars have for a long time noticed connections between art broadly speaking and doctors' practice – in doctors' training and professional development, for instance.[584] Sketching in some of these connections will help to show how historians have stopped short, as it were, and so will prepare the way for our case-studies.

Anatomy

The strongest connection between art and doctors' practice was surely anatomy. Art and medicine shared a mutually beneficial investment in anatomy. Artists learned how to draw bodies by anatomised cadavers. It was logical for the Royal Academy to institute a

[580] Chambers, 'Fragmented Identities'.
[581] See Park, *Art in madness*, esp. 41ff. for the breadth of her remit; on portraits, cf. *ibid.*, 92, 107.
[582] www2.streamingwizard.com/clients/rcpe/emery271010/emery.swf; accessed 19th April, 2012.
[583] See e.g. B. Nance, *Turquet de Mayerne as Baroque Physician: The Art of Medical Portraiture* (Amsterdam and New York, 2001); C. Stein, *Negotiating the French Pox in early-modern Germany* (Farnham and Burlington, 2009), 15-6.
[584] With this, cf. Lawrence, *Charitable Knowledge*, 23-6.

professor of anatomy in *accoucheur* and anatomist, William Hunter.[585] Meanwhile, a canonical medical training prescribed an intimate knowledge of anatomy, which was partly gained by drawing. Anatomists were expected to observe intently, recognise accurately and draw proficiently all the complexities of the human form. Anatomists like master of the College of Surgeons, William Cheselden, set their stall by the acuity of their representations of the body. Cheselden's plates even included anatomical renderings of classical art. Plate twenty in his *Anatomy of the Human Body* (1740) was "done after the famous statue of Hercules and Antaeus...the figures are omitted to preserve the beauty of the plate."[586] Johan Zoffany immortalised this mutual relationship in two paintings of Royal Academicians at life-drawing school (see Figure 73).[587]

This knowledge was also reinforced by looking at works of art. Specifically, anatomists scrutinised painstakingly detailed engravings of body parts in big medical text-books. Text-books were commonly peppered with large folio engravings of skeletons, the musculature, the circulation system, and so on. These plates were the work of art professionals whose technical expertise was revered and competed for.[588] Cheselden exemplifies these trends, too (cf. chap. IV).

Early-modern English doctors cultivated their sensitivity to art beyond their professional responsibilities, however. Being 'lay' aspirants to high, learned culture, they sought knowledge about aesthetics and art history. Often, this surpassed the general knowledge noted in the Introduction and chapter I. It could even rise to the level of the connoisseur or virtuoso.[589] Early-modern doctors wrote squarely on aesthetics, the eye and the mechanics of vision in their efforts to assume the status of natural philosophers.

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[585] See A. Darlington, 'The teaching of anatomy and the Royal Academy', *Journal of Art and Design Education*, 1986, 5, 263-71; M. Kemp (ed.), *Dr William Hunter at the Royal Academy of Arts* (Glasgow, 1975).
[586] W. Cheselden, *The Anatomy of the Human Body* (London, 1740), 130-1.
[587] Porter, *Bodies Politic*, 69.
[588] The unpublished work of Stephen Benson has begun to unpick these networks. See S. Benson, 'Left out of the Story? Engravers in the cultural networks of the early eighteenth century', Uni. of London M.A. thesis, 2010. I am grateful to Mr Benson for discussing his thesis with me.
[589] C. A. Hanson, *The English Virtuoso: Art, Medicine and Antiquarianism in the age of Empiricism* (Chicago, 2009).

William Salmon's *Polygraphice* (1672) epitomised this. Doctors were also voracious collectors of fine art, engravings, curiosities, antiquities and other valuable things that caught the eye and demonstrated (even if rather ostentatiously) their appreciation of artistic skill. Drs Hans Sloane and Richard Mead are perhaps the most notable exemplars of this trend. Some doctors were simply very good painters in their own right and used their skills to propel themselves towards politeness, fashion and taste.[590] In many respects, then, theirs was a more discerning "period eye".[591]

Doctors, bodies and the notion of the portrait

Anatomical drawings accustomed doctors to drawing the body. Portraits, of course, were a highly culturally-charged means of representing the body, as the first two chapters have shown. Importantly, contemporaries allowed the term 'portrait' to stand for and label any purportedly accurate representation or likeness of body parts or fragments.[592] These need not necessarily have included the face, which was of course the fragment most often depicted by a portraitist. William Hunter's understanding of his plates in his treatise on the *Gravid Uterus* (1774) captured this wider sense. The dissected *torsos* of his pregnant cadavers were "simple *portrait*[*s*], in which the object is represented exactly as it was seen" – to the point where the derived image "bears the truth and becomes almost as infallible as the object itself."[593] Knowledge was gained by putting together these fragmented portraits.[594]

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590 Dr. Hurd, a physician from Leeds, painted a self-portrait that Horace Walpole commented on during a trip to Yorkshire: see Walpole, *Visits to Country Seats*, 74.

591 Cf. Baxandall, *Painting and Experience*.

592 This figurative use dates from the middle of the sixteenth century, and seems to have been used alongside – and no less rarely than – the definition which we commonly recognise today; OED: "portrait". Indeed, the compound nouns "portrait bust" and "portrait head" – i.e. which specify precise fragments of the body – date only from the second quarter of the nineteenth century; *ibid*. The general point is that the word portrait formerly connoted a far greater range of meanings than it currently does.

593 W. Hunter, *On the anatomy of the Gravid Uterus* (1774), preface. Emphasis added.

594 With this, cf. Stafford, *Body Criticism*, 140; Chambers, 'Fragmented Identities', 588.

This conception has more than semantic pedigree. As scholars like Marcia Pointon have explained, plain likeness was an increasingly problematic yardstick of identity. Many eighteenth-century portraits encouraged viewers to infer 'identity' through the precise portrayal of body parts. Pointon has focussed on the tradition of portraying men's legs and specifically their toned calves.[595] As a category and a medium, a portrait encoded a representation of anyone whose 'likeness' was a tangle of individuating and culturally-situating signs.

Recognising this allows us to expand the term 'portrait' to include named cases – where an individual's parts were drawn – and post-mortem portraits. It is important, however, to recognise that it this conception might only have been realised – or activated, perhaps – in the openly medical circumstances analysed in this chapter and the next. Barring faces, not many body parts adorned the walls of eighteenth-century country houses; and the reader will note that we have not come across 'body-part' portraits (except busts) in the first two chapters.

The medical gaze

To argue that portraits inscribed early-modern medical ways of looking is to link artistic practice with medical vision. Medical vision has been much studied. Michel Foucault claimed that (hospital) patients were increasingly objects of an institutionally generated 'gaze' that reduced them to a series of visual medical problems. Only the trained eye of the doctor could decipher these visual "codes of knowledge".[596] Indeed, the trained eye came to supersede the other sense organs and became, for Foucault, the "absolute eye of knowledge".[597] This argument has been pursued with most vigour for the early nineteenth

[595] Pointon, *Portrayal and the Search for Identity*, 134ff, esp. 147-54.
[596] Foucault, *Birth of the Clinic*, 90-1.
[597] Cit. N. A. Anderson and M. R. Dietrich, 'Introduction: Visual Lessons and the Life Sciences', in *iidem*, (eds.), *The Educated Eye: Visual Culture and Pedagogy in the Life Sciences* (Hanover, NH, 2012), 1-28, at 1.

century and thereafter,[598] although Mary Fissell's account of case notes from Bristol's infirmary supplies evidence of this sort of objectifying looking in the eighteenth century.[599] Indeed, as Bernard Mandeville commented as early as 1711, "Physicians feel the Pulse, and inspect the Tongue, and Urine of the Patient, but there are other things to be taken notice of in the Eyes and Face of Sick People, that cannot be express'd, and yet yield more certain Rules for Prognostication, to those that are vers'd in them."[600] Diseases, in other words, could be encoded in bodily signs. Looking became a privileged medical activity.[601] Doctors jealously guarded their expertise in looking – whether at actual or represented bodies (cf. chap. IV).

Certain specific medical practices gave rise to specific gazes. Physiognomy relied on gazing at facial profiles and silhouettes (hence from certain angles). Phrenology required a doctor to gaze at (and feel) the contours of the skull.[602] Classifications and typologies emerged from visual difference, for instance in Willan's, Bateman's and (Frenchman) d'Alibert's dermatological charts. Gazing on the curious was legitimised in part 'pathologically', as we saw in chapter II. Indeed, the notion of the gaze has forced historians to query how the body – the thing gazed on – can be conceptualised as historically contingent on medical practices.[603] Without ascribing a particular type of gaze to the doctors (or only to the doctors) in the case-studies, this chapter considers how medical gazes impinge on representations of the (objectify-able) body. What was the difference between gazing on physically presented bodies and artistically represented bodies, when both were looked at for what they signified about illness?

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[598] See e.g. D. Armstrong, 'The rise of surveillance medicine', *Sociology of Health and Illness*, 17, 3 (1995), 393-404.

[599] See e.g. Fissell, *Patients, power and the poor*, 148; with it, cf. Lawrence, *Charitable Knowledge*, 26.

[600] B. Mandeville, *A treatise of the hypochondriack and hysterick passions* (London, 1711), 68-9.

[601] On the senses, see Bynum and Porter (eds.), *Medicine and the five senses*. For an interesting example of portraiture's role in signalling the change from favouring sight to favouring touch in the late nineteenth century, see Henry James Brooks' *The Viva* (1894). I am grateful to Keren Hammerschlag for this reference.

[602] See O. Weisser, 'Boils, Pushes and Wheals: Reading bumps on the Body in Early Modern England', *Social History of Medicine*, 22, 2 (2009), 321-339.

[603] E.g., Duden, *The woman beneath the skin*; Churchill, 'The Medical Practice of the Sexed Body'.

John Hunter's patients: portraying medical principles

John Hunter (1727/8-93) is widely known to historians of medicine as a pioneering surgeon, teacher of anatomy and collector of anatomical specimens. He has long been in the pantheon of doctors; the Royal College of Surgeons is his present-day temple. Hunter occupied himself with all sorts of medical practice. Having left Scotland, he helped his brother, William, with his anatomy demonstrations. He learnt surgery under William Cheselden in Chelsea and Percival Pott in St. Bart's and then at St. George's. After an unhappy spell at Oxford, he took up dentistry under James Spence back in London. He gave private anatomy classes on the side. He became a military surgeon during the Seven Years War. Only after he became licensed to the Company of Surgeons in 1768 did he settle into a combination of private practice and hospital work at St. George's.[604]

Hunter's practice involved in-house hospital work as well as travel. He noted that he reserved on average two and a half hours per day for home visits. His patients ranged from common labourers to the cream of society, right up to the prime minister the Marquess of Rockingham and Frederick Cornwallis, the Archbishop of Canterbury. Besides his medical livelihood, Hunter also fostered wider natural historical interests. He housed an enormous collection of exotic animal species at his home in Earl's Court, for instance. His publications give a flavour of the diversity of his interests: teeth, blood, venereal disease, gunshot wounds. And in 1786, he brought together various papers delivered to the Royal Society in a volume *On the Animal Oeconomy*.

Hunter is also known – as we read in chapter I – for his portrait by Joshua Reynolds, which set a standard for many other doctors' portraits.[605] Indeed, Hunter's

[604] DNB. See also J. Dobson, *John Hunter* (Edinburgh and London, 1969); G. Qvist, *John Hunter, 1728-1793* (London, 1981); S. Chaplin, 'John Hunter and the Museum Oeconomy, 1750-1800', Uni. of London Ph.D. thesis, 2009.

[605] Cf. Sarafianos, 'Natural History of Man'.

exposure to art was quite concerted. He was the pupil of an anatomist renowned for his attention to visual accuracy (the aforementioned William Cheselden). Jessie Dobson has explained that John assisted draughtsman Jan Rymsdyk in the preparation of his brother's *Gravid Uterus*.[606] (John would commission Rymsdyk himself directly, too, as we shall see.) We know that Hunter collected and commissioned many portraits, including those linked to his museum 'project'.[607] And we know that he discussed visual and artistic matters with friends and colleagues. For instance, Hunter corresponded with his long-term friend and erstwhile patient Edward Jenner on optics and colour just before his death in 1793.[608] In fact, Hunter went on record about medicine's relationship with art by declaring himself in favour of "tolerably correct anatomical description[s]" being complemented "with...accurate drawing[s] of the external form". By writing and drawing, he could capture the surface and the interior of the body as accurately as possible.

These last comments chime with Simon Chaplin's convincing hypothesis that Hunter's practice as a surgeon-anatomist tallied with the principles of his work on the animal oeconomy.[609] Hunter sought to combine the insights of surgical practice – gleaned by patient histories and exact observations – with pathological morbid anatomy – by dissection – in order to understand fully the nature of the diseases his and other patients suffered from. That is, he sought knowledge of both inside and out. It is with this specific background in mind that I turn to portraits of Hunter's patients, which have received next to no attention.[610] My questions are: how do they correlate with Hunter's broad medical endeavour? – and how, therefore, did they tie into his work as a doctor?

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606 Dobson, *John Hunter*, 29.

607 Boruwlaski's was one such. Those portraits deemed unrelated to the project were sold at auction after Hunter's death.

608 J. Hunter, *The Surgical Works of John Hunter*, (ed. J. F. Palmer, London, 4 vols.., 1835-7) i, 89-90.

609 See esp. S. Chaplin, 'Nature dissected or dissection naturalized? The case of John Hunter's museum', *Museum and Society*, 6, 2 (2008), 135-51. The point has been also made indirectly by Cunningham, *Anatomists Anatomis'd*, 336; and J S. C. Jacyna, 'Images of John Hunter in the nineteenth century', *History of Science*, 21 (1983), 85-108.

610 The exception to the sidestepping rule is William LeFanu; see below. Elsewhere, Simon Chaplin's thesis on Hunter's collecting habits includes an understandably cursory summary of the drawings: Chaplin, 'John Hunter and the Museum Oeconomy', 328ff. Blandy and Lumley's history of the College of Surgeons'

Indeed, exploring these questions leads me to make a number of arguments about the uses and functions of portraiture in Hunter's practice. The first is simply that they served a number of functions. They could be clinical *aides-memoire*. They could also be pre- and post-operational analytical tools, often used alongside preparations. These uses closely relate to Hunter's avowed principles of human anatomy. The second argument is that doctors used portraits to communicate about cases among themselves. Portraits could 'bridge' the physical absence of a patient. The third argument is that recognising the origins of patient portraits in Hunter's practice forces us to complicate how we might understand doctor-patient relations.

The portraits themselves are housed in Hunter's drawing books in the Hunterian Museum of the Royal College of Surgeons. These books contain some 900-odd drawings. Many are of natural historical specimens.[611] The drawings were compiled and catalogued en masse from 1824 onwards by William Clift, Hunter's stalwart assistant and amanuensis. Clift's tireless efforts to make sense of the Hunterian manuscripts and preparations led him to make his own annotations on the drawings, including to note the names of some of those whom Hunter had preferred not to name (particularly those of a higher social station). Hunter's and Clift's annotations are liberally scattered over the drawings; fortunately, their hands are different enough to tell them apart. As well as identifications, Clift's annotations also include cross-references to other materials (including the *Philosophical Transactions* of the Royal Society, of which Hunter was a fellow).

Hunter left no indication of why particular cases were sketched and/or written up in the first place.[612] We may deduce from 'within' the case, but Hunter never explicitly

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collection stops at describing them a "treasure chest": J. P. Blandy and J. S. P. Lumley, *The Royal College of Surgeons of England: 200 Years of History at the Millennium* (London, 2000), 176. Finally, John Kirkup mined them (briefly) for information about surgical procedure: J. Kirkup, 'John Hunter's Surgical Instruments and Operative Procedures', *Vesalius*, 1, 1 (1995), 22-6.

[611] William LeFanu discussed those particular drawings a generation ago. W. LeFanu, 'Natural history drawings collected by John Hunter F.R.S. (1728-1993), at the Royal College of Surgeons', *Journal of the Society for the Bibliography of Natural History*, 8, 4 (1978), 329-333.

[612] With this, cf. E. Allen, R. Murley and J. L. Turk (eds.), *The Case Books of John Hunter FRS* (London, 1993).

declared up front that a case "was an interesting case of '*x*', or fascinating because of *y*". Moreover, it is doubtful whether Hunter even intended the portraits of patients ever to exist – let alone to be presented – side-by-side. (Clift's associations can give the impression that they were linked.) They were free-standing and applicable only to their respective cases (see below). All this does not mean that we cannot analyse the drawings and surrounding documents. We just have to bear in mind that Clift was responsible for some of the pre-analytical connections and that Hunter did not see fit to explain himself.

Clinical portraits

One approach to understanding the portraits is as direct diagnostic tools and clinical records. The word 'direct' needs some elaboration. Hunter did not make the drawings himself. Most of the portrait drawings were made by William Bell, another of Hunter's assistants who worked with him from 1775 till 1789. However, relevant case notes and annotations show that Hunter used them to make sense of his patients' problems.

The first example is of a before-and-after pair of portraits. In 1785, Bell made two drawings of John Burley, a 37 year old rigger who presented to Hunter with a tumour on the left hand side of his neck (Figures 74 and 75).[613] Between 1769 and 1785, it had swelled enormously.[614] As Hunter annotated, one drawing was made "before the tumor was dissected out and the other <u>after</u> it had been removed." Hunter tells us explicitly that they offered a comparison of two points in his clinical procedure. Both portraits are pen and watercolour drawings on card. Both are half-length. Each is overlaid with tracing paper, onto which minimal traces have been made. (It is not clear whether Bell made these, too.) Burley is set in no background. There is no sense of time or place. Burley looks off, with a neutral expression.

[613] RCSEng HDB/4/2/386Aa, f. 1.
[614] RCSEng HDB/4/2/386Aa, f. 1.

In the first drawing, the dark ink and scant colouring help to convey what Hunter referred to on seeing Burley as his "dark complexion".[615] Burley's tumour is rendered bulbous by the heavy outline and the deep shadow which it casts underneath (to the bottom right as we look). Hunter noted that "the tumour...is hard to feel in some places, in others softer, as if containing a fluid...and [it] may be moved easily without giving pain."[616] Bell's rendering of the surface of the skin supports this observation: he paid particular attention to two protrusions which face the viewer as well as to a protrusion to the right, which causes the skin at the top to appear softer. Indeed, when Hunter looked at the drawing, he noted that "it is a true representation of the man, so far as was connected with the Tumor, and the tumor itself keeping close to proportion in size".[617] Hunter made immediate recourse to portraiture to record the clinical details of the tumour; text, in the form of case-note annotations, came later and only to confirm what the portrait showed. Importantly, for Hunter, it was an accurate record of the outward view of the patient.

Hunter operated on Burley for 25 minutes on 24thOctober, 1785.[618] Some time afterwards, Burley again sat to be drawn. The post-op. drawing is, stylistically, very akin to the first. It seems the point of the second was to chart the lines of the surgical incisions. Again, Hunter's annotations explain that the second portrait "is nearly a profile view of the left side, which shows the neck with the bicatrix which is little more than a line reaching from before the Ear...to within a little of the sternum also a broader cicatrix passing from the above line forward under the jaw."[619]The drawing showed the signs of the operation. Burley's face became the canvas on which the principal clinical actions were documented and the signs inscribed – literally the scars of the medical transaction.

Other cases also indicate the use of portraits to diagnose and record the status of patients and their complaints. In 1781, Bell sketched in close-up a case of a build-up of

[615] RCSEng HDB/4/2/387a.
[616] RCSEng HDB/4/2/386Aa, f. 2.
[617] RCSEng HDB/4/2/386Ab.
[618] RCSEng HDB/4/2/386Aa, ff. 2-3.
[619] RCSEng HDB/4/2/386Ab.

menstrual blood in 14-year old Miss Miller, which was caused by an imperforate hymen (Figure 76). The gaze evinced by the portrait focused solely and squarely on the clinical problem.[620] In another case, Bell drew a stoma on the abdomen in the case of an Italian hairdresser whom Hunter saw at St. George's. Hunter noted that the stoma "had been down nine days, which gave rise to the appearance I observed in the operation." It is unclear during exactly which of the three operations to remove the stricture that Bell's drawing was made, but it is important that it was "in the operation". In Hunter's *Principles of Surgery*, he wrote up a case of hydrocele. Within the case note, one reads that

> all over the tunica vaginalis there were a great many vessels full of blood, and in many parts coagula of blood like extravasation. *In this state* I had a drawing made of it, and a small part magnified to show the vessels and the dots...[621]

The drawing was a major part of the clinical record. It was even partly magnified to capture the most relevant morbid details.

In each of these cases, portraits showed the outward signs of an illness. These signs relate closely to how Hunter thought diseases were contracted and how they became visible. Indeed, "signs" were Hunter's word for the end point of the chain of contracting diseases. A person's individual constitution affected their "susceptibility" to "impressions"; these impressions formed dispositions; and these dispose people more or less to action, "which action becomes the immediate sign of the disease, all of which will be according to the nature of the impression and of the part impressed".[622] Diseases were "dispositions for a wrong action" – i.e., one which goes against natural bodily function.[623] Indeed, "the ultimate and visible effect of disease is action; but this is not the disease, for the action is

[620] RCSEng HDB/3/1/857/1.
[621] The case is at Palmer (ed.), *Works of John Hunter*, i, 236ff. Emphasis added.
[622] Palmer (ed.), *Works of John Hunter*, i, 301.
[623] Palmer (ed.) ,*Works of John Hunter*, i, 299, 310.

only an effect, a sign or symptom of disease."[624] Hunter's clinical use of portraits was intimately bound up with how he thought diseases manifested themselves. Portraits allowed him to record the signs of actions, the most visible manifestation of someone being, in Hunter's phrase, "under disease".[625]

As well as attesting to this sort of clinical use, other cases demonstrate how portraits fitted in with the 'inside-outside' medical strategy that Chaplin noted. Indeed, portraits operated differently according to whether they were 'inside' or 'outside' drawings. In 1755, eight-year-old Jonathan Burn was admitted to St. George's with water on the brain. After some ineffectual treatments, the boy died on 20th November. The case notes describe how "after making two Drawings of the head and face, I made an incision over the head from ear to ear...." Hunter here conflated his and his assistant's work, for Hunter had called upon Rymsdyk to draw Burn. It is important that Rymsdyk is not erased from the historical account, but equally significant that Hunter claims them as *his* documents (cf. chap. IV).[626]

Rymsdyk's drawings are in striking reddish sepia pastel on paper (Figures 77 and 78). The pose and angle of the two pre-dissection drawings dwelt on the size and shape of the head, as one might expect. One was taken from the vantage of young Burn's lower half, looking obliquely up the body toward the head.[627] Classical perspective would have more distant objects appear smaller, yet Burn's head looms large as the view recedes. The head swells into the 'distance', enlarging the relative scale of the condition and making it dominate the sheet. The depiction of the narrow eyes captures perfectly in a few strokes that "his eyes were depressed by the orbiter process of the *Os Frontis*, being pressed down

[624] Palmer (ed.), *Works of John Hunter*, i, 310-1.
[625] Palmer (ed.), *Works of John Hunter*, i, 315.
[626] This relates closely to the histories of studio and workshop manufacture, where assistants would do the bulk of the work, but the master would attach his signature. Peter Lely and Godfrey Kneller were just such artists; Lely would even contract separately with clients who were willing to pay more to have him carry out all the work. For the example of (master) Josiah Wedgwood and (assistant) William Hackwood, see J. Uglow, *The Lunar Men: Five Friends Whose Curiosity Changed the World* (New York, 2002), 325.
[627] RCSEng HDB/4/2/405.

by the weight of the water so that the eyes were behind the under Eyelids for several weeks before death."[628] The second drawing, almost as big as the first *ad vivum* sketch, refines the description of the condition in a few long flat strokes of chalk[629]. So, too, did a third drawing that Hunter made of Burn tucked up in a sheet (Figure 79).

The combination of these drawings (two 'frontal', one reclined profile) offers a full sense of the dimensions of the skull – certainly fuller than frontal portraits by themselves. Indeed, Hunter (himself) drew a fourth portrait of Burn in the case notes, which demonstrates that Burn's head was at least "as wide as his shoulders".[630] This drawing in fact precedes Hunter's precise measurements of the skull: "The length of the head was nine inches. Round the head horizontally, two feet three inches. Round the head perpendicularly, two feet two inches." The four drawings taken together formed the clinical record of the *status quo* before dissection. They were the final part of what we might call the observation phase of the case. Importantly, the drawings were allowed to speak for themselves – they were not elaborated on, save to give precise dimensions.

However, when Hunter began dissecting Burn, the annotations became more descriptive:

> I first scalped him and then cliped [*sic*] the skull all round, as low as I possibly could, the water immediately flowed out when the whole was removed I observed that the brain lined the scull every was [way?], and in some places it was no thicker than brown paper. The following drawing is a view of the basis of the scull covered...with the Brain just as this hart was in the living body [*sic*].[631]

[628] RCSEng HDB/4/2/404A. In an inscription on the first drawing, Clift describes the case as being in "Hunterian MSS Transcript / vol. III fo. 11 – J Burn, 1755, his case".
[629] RCSEng HDB/4/2/406.
[630] Allen, Murley and Turk (eds.), *Case Books of John Hunter*, 530-1.
[631] RCSEng HDB/4/2/404A.

The drawing was to capture the immediate *post mortem* appearance (Figure 80).[632] It was a part of the initial clinical assessment after death. But a longer function was imagined for the drawing. Hunter envisioned others looking at it. He wanted it to make sense to them. A note at the top of the sheet was written upside down as follows:

> This drawing was made with the parts in this position. If it is examined the other way, all the lights & shadows are wrong.

There seems to be a discursive division between the drawings of the observation and dissection phases – a divide between how self-expressive they were. Those of the observation phase needed next to no elaboration at all, whereas those of the dissection phase were elaborated on. This offers a telling glimpse into what a proficient anatomist thought was plain and what he thought required extra detail – i.e. to what extent he thought portraits spoke by themselves or required elaboration in a clinical setting. The example also shows how the meaning of the portraits could emerge after their initial use. Hunter's annotations pre-empted how a portrait might be seen and understood; and they gestured subsequent viewers towards a certain way of looking at it.

A second case demonstrates a similar division between pre and post dissection. In this case, portraiture complements another sort of material cultural deposit – namely, Hunter's preparations. In 1785, Thomas Norman, a 55-year old soldier, was treated for an aortic aneurism, which "appear[ed] externally in the form of a Tumor". The case-notes indicate that Norman originally noticed a tumour of "about the size of the tip of his finger", but it had swelled "a day or two before his death [to a] circumference at its basis...[of] 26 inches". These dimensions mean that Bell's sketch of Norman will have been taken at some point between these two sizes. The drawing certainly preceded the written record of the case. It was a mid-case depiction. The portrait captured the patient betraying

[632] RCSEng HDB/4/2/407a.

very little expression, as in the case of Burley (Figure 81). Unlike in Burley's portraits, however, there is no colour to embellish the skin. No attention is really paid to the face at all. Indeed, the texture is more delicate and the draughtsmanship more deliberate around the tumour itself. The sweeps of curved lines gesture the viewer's eyes toward the leaf-shaped wounding of the skin in the middle of the tumour. It is as though the portrait is brought into focus only on the surgical problem.[633]

As well as taking this portrait, Hunter also made four preparations from Norman's body: three wet-prepared coagula and the dry-prepared thorax with the arch of the aorta, showing the aneurism itself (Figures 82-85).[634] These along with the portrait literally embody the complementary phases or modes of Hunter's medical practice that Chaplin noted: living observation and description on the one hand, and dissection and analysis of the morbid anatomy on the other. Norman's portrait was the focal part of the first phase of Hunter's practice.

Before we move to another feature of patient portraiture in Hunter's practice, it is worth dwelling on the fact that, in all of the cases mentioned until now, assistants have contributed to the diagnostic looking and showing process. Hunter's patients were exposed not only to his clinical eyes, but those of Hunter's draughtsmen, too. A couple of things follow. First, assistants' looking dictated the recording of a case as much as the lead doctor: in Burn's case, both Rymsdyk's and Hunter's looking contributed to the recording of the case. (It is worth pointing out that no formal instructions to Hunter's draughtsmen have survived for any case, so it is unclear precisely why and on what terms Hunter shared the task of drawing between himself and his assistants.)

Second, if we accept that these portraits served even the most basic clinical function, then we face a more complicated clinical dynamic than a simple doctor-patient

[633] RCSEng HDB/4/2/410/1.

[634] Patients' histories were also attached to such preparations, and were even available to visitors to his museum; Chaplin, 'John Hunter and the Museum Oeconomy', 227-8, 232-3.

one. Artists were 'in the room', like nurses in later generations. They, too, gazed on patients. They partly determined the psychodynamics of looking and being looked at.[635]

Indeed, these dynamics challenge us to re-think typical models of a medical encounter involving only two active categories (patient and practitioner). A far subtler interaction in fact took place. It was one in which a practitioner – often a pretender to the sanctioned medical faculty – used artistic skills to observe a patient clinically in order to produce a drawing for another practitioner to look at. Doctors were at once viewers as well as producers of art. This fact has implications for the patient's status as the person viewed. Not only did this interaction visually objectify patients in two different ways – objects of sight, objects of art – but it also made them a vehicle of the artistic inscription of medical knowledge. Patients became subject-matter, too. This particular interaction made the patient at once a subject and an object – but a different kind of subject or object for the different practitioners in the interaction. Patients' status as looked-at people depended directly on the medical practices of different practitioners, including artists-cum-assistants.

The traffic in patient portraiture among doctors

I move now to consider the movement of portraits among Hunter and some of his fellow practitioners. Hunter received many portraits of patients from other doctors. These were sent to him so that he could comment on the patients-cum-sitters 'remotely'. If we know that patients were apt to put their health into the hands of many doctors, we are less aware of instances where several doctors knowingly interacted on a case as part of their private practices (we know that they did in hospitals) – let alone by using portraits.[636] Moreover, most of the work done on doctors' interaction has concerned their efforts to contribute to, and so advance their stake in, learned discourses and communities – basically to converse

[635] Cf. Rosenthal, 'She's got the look!'.
[636] With this, cf. Lawrence, *Charitable Knowledge*, 24.

with their intellectual peers. It is worth asking how portraits of patients contributed to this process. In what ways were they components of a doctor's occupational sociability?[637]

One case that Hunter received in the post centred on a supposedly deranged "idiot" detained at Pentrey in Norfolk.[638] This patient was twice portrayed, supposedly in the positions he most often assumed and with the poses he most often struck (Figures 86 and 87). The original portraits were made by one Lady Beaumont, whose sketches were copied by a Mr Bailey of Swaffham. Bailey noted that he had copied "very slight sketches", i.e. sketches that had not taken Beaumont long to draw (cf. chap. I). Bailey sent them to Hunter in advance of a letter from an unsigned correspondent from Stowmarket that related his observations of the man.

These images prefigured the information in the letter. The two drawings depict the man cross-legged hunching forward and then in a sort of sitting foetal position. His expression is severe in both – his eyes are narrow, his brow furrowed and his cheeks sunken. His hair is dishevelled. He is naked. The letter elaborates on these depictions by referring to invisible signs – such as that the patient was "praeternaturally hot". The letter was written to arouse Hunter's interest in the case. The writer even told Hunter that he had first refusal of the corpse of the man "if he should be released from his imprisonment". On both accounts, the portraits acted as a preview, a visual epilogue of further medical information to come. Indeed, the letter supplements what the portraits had already shown. I do not know if Hunter replied to this letter, but the portraits imparted a clinical observation to him. They showed illness to whet Hunter's anatomical appetite.

Hunter also received drawings in the case of James Jones in 1779 (Figure 88). Dr Richard Cheston of Gloucester infirmary was the primary caregiver. (He would write the case up in 1780for the Royal Society's *Philosophical Transactions*.) He described Jones' pains in the hip and knee, various inflammations and the ossification of the thoracic duct, from

[637] On portraits and conversation, see L. J. Jordanova, 'Portraiture and Conversation in Britain 1800-1830' in K. Halsey and J. Slinn, *The concept and practice of conversation in the long eighteenth century* (Newcastle, 2008), 151-69.
[638] All the material is contained under a single entry: RCSEng HDB/3/1/843A/1.

which last he died. He separately described the state of the pelvis "after a maceration of five months". Hunter was one of four doctors who shared in the post-mortem discussion of Jones. A letter, presumably from Cheston, since it was addressed from Gloucester, explains how "a painting [of the pelvis]...well apprises the appearance of the boney Matter so largely & so singularly dispersed over it." It was deemed an accurate record. Cheston explained that "Mr J Hunter wanted to add to it [i.e. the account] some observations on the...case. I have therefore sent it to him with a Drawing about a week ago."[639]

We get further indication of how Cheston thought the drawing would provide Hunter with an accurate portrayal of Jones, since his write-up in the *Transactions* included "an explanation of the drawings" that only amounted to two remarks because it "is so expressive of the original". (The copy that was sent to Hunter bears an almost identical resemblance to the one that (Karl?) Rickelts drew for James Basire to engrave for the *Transactions* (Figure 89).) The drawn images provided the various consulting clinicians with their basic view of the case. The visual depiction remained all but constant no matter what was then written about it. Like in the Norfolk case, portraits were pivotal to this medical transaction, even though it covered a great distance and involved several practitioners.

Another case that made it to the pages of the *Transactions* was discussed by portraiture. The case of Peruntaloo – referred to Hunter in 1788 – again shows how portraits could supplement written descriptions.[640] In February, 1788, Dr Anderson wrote to Hunter outlining the remarkable case of a young boy whose brother lived within him parasitically. Anderson explained:

> The little brother is suspended in the Os Pubis...The alimentary canal must be common to both, as the anus of the little one is imperforate...Peruntaloo says he has as compleat a sense of feeling with every part of...his little brother as of his own proper Body.[641]

[639] RCSEng HDB/4/2/389A.
[640] RCSEng HDB/3/1/845/1.
[641] Anderson to Hunter, 25th February, 1788, in RCSEng HDB/3/1/845/1.

Others were interested in Peruntaloo's case. Within the small bundle of documents is a letter from Baron Thomas Reichel to Sir Joseph Banks, the naturalist-explorer. Reichel had made a drawing of Peruntaloo, which he shared with Banks (Figure 90):

> I have the pleasure to transmit to you, the portrait of a Gentoo boy...I made the two drawings representing the alternate attitudes he can place half the Body of his little brother in, who adheres to his breast....In addition to the enclosed anatomical description...by Dr Anderson, you will observe in the drawing two circular dotted lines, about the lower part of the loins...During the several sittings I had of Peruntaloo I observed an internal motion about these parts, rather more conspicuous than any other part of the Body, and...he showed me that by retaining his breath, he could force a current of air in them so as to swell the parts like two blown up Bladders.[642]

Banks forwarded this letter and Reichel's drawings to Hunter for his inspection. Here was a community of doctors discussing and working through the same case with the help of portraits. (For Hunter, they came after an initial textual description.) Reichel thought Banks would profit from a (diagrammatically precise) portrait, and Banks thought Hunter would, too. Reichel's use of the term "sitting" is also significant. The whole point of the transaction was to gaze at a patient in order to show his condition. Peruntaloo's case is also another example of a portrait's meaning emerging by being used after being made: it gained meaning as it was physically passed around to share clinical information.

Reichel's portrait was considered diagrammatically precise. It elucidated medical knowledge. It did so with specific techniques like the "circular dotted lines" (cf. chap. IV).[643] As about drawings that his assistants made, so Hunter cared about the accuracy of drawings that were sent to him. Ambrose Isted's case was referred to Hunter by William

[642] Baron Reichel to Joseph Banks, 28th February, 1788; RCSEng HDB/4/2/845/1.
[643] On Hunter's use of naturalistic objects, see Chaplin, 'John Hunter and the Museum Oeconomy', 123.

Kerr, a Northampton surgeon. Kerr sent Hunter his (or perhaps his own assistant's) drawings. Yet Hunter thought them "not made by one conversant with such subjects; the parts were stuffed so as to extend them, that they might be better made out."[644] Hunter worried that the parts had been tampered with and that they had been made by someone unaware of what he was looking at. Drawings were too important to be sub-standard. They had to be made by knowledgeable eyes. Isted's case-portraits expose how Hunter thought drawings embodied a certain type of medical and artistic skill, which he imputed to himself and presumably to his assistants. Hunter had Bell recopy them, and wrote on his new copies that "these Drawings were taken from parts of Mr Isted, a Gentleman long afflicted with a pain in the Back in the Right side; had often bloody stools, and who died suddenly." Hunter's annotations supplemented drawings which were sent from another doctor but which Hunter had remade to his own exacting specifications. The portraits reinforced Hunter's (self-confessed) status in a community of medical men who were self-professedly qualified to look. This prefigures the next chapter's enquiry into how portraits sustained relationships that were founded on shared skills and appreciation of specific techniques.

This section has queried how portraits could bridge the gaps that inhered in diagnosis and investigation at a distance. Portraits of patients seemed to stand in as reliable substitutes – or unreliable substitutes in Isted's case – for physical bodies and body parts. They allowed inspection from afar. And in the Norfolk case, they prepared Hunter for subsequent stages of his medical practice (i.e. dissection).This sub-genre of medical portraiture therefore aligns closely with theories of portraiture as old as Aristotle that deem portraits mimetic substitutes for the actual people they represent.[645] They were the basis for interactive discussion of medical matters. Moreover, they also link to wider cultural trends,

[644] RCSEng HDB/4/2/407A, 408a.
[645] Cf. Woodall, 'Introduction'. Géricault's portraits of the insane also stood in for the real patients: see J. M. MacGregor, *The Discovery of the Art of the Insane* (Princeton, 1989), 42-3.

including wider medical and proto-scientific communities' sharing items of material culture in their studies.[646]

Interim conclusions

This case-study suggests some important interim conclusions. We might first recognise just how full of portraits Hunter's practice was. Moreover, it was full of (formally) different kinds of portraits. There was no apparent 'Hunterian' style or type.[647] The different portraits helped Hunter to make sense of the cases he dealt with. They performed and inscribed knowledge and medical skills – especially close looking. They matched his conceptualisation of the signs of diseases. If portraits were crucial to the performance of medical tasks and the understanding of how diseases looked, it suggests how crucial art was in clinical medicine – how embedded it was in 'normal' everyday practices.

Second, we can say that, for Hunter, portraits were stand-alones. They were not designed to be comparable. Rather, they were individualised. This point is also discernible from the way certain cases got written up. For instance, Hunter – via his engraver, William Sharp – dropped Captain Graham's identity from the write-up of Graham's genital problem. Yet Hunter welded the original drawings inextricably to the facts of the individual case – a mortification of the bladder. Hunter literally wrote all over the original drawings.[648]Chapter IV will elaborate on this sort of portrait publication.

Having mentioned writing all over original drawings, a third conclusion concerns the relationship between text and image. It might just be because we have paid closer attention to portraits, but in these examples text appears auxiliary, even ancillary, in the medical 'effort'. The least we can say is that art seemed to be doing as much work for

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[646] See Hanson, *English Virtuoso*.

[647] This is at odds with the argument recently proposed by Carin Berkowitz, 'Knowledge claims, authorship and aesthetics in the anatomical atlases of Enlightenment Britain', paper delivered to the American Association for the History of Medicine conference, Baltimore, 28th April, 2012.

[648] RCSEng HDB/4/2/395; J. Hunter, *Treatise on the Venereal Disease* (London, 1786), plate 4.

Hunter as text. Indeed, they were mutually reinforcing forms of clinical communication in Hunter's practice, not least in his engagement with other doctors. Drawings could both prefigure and confirm textual information, and *vice versa*.

A fourth conclusion is that the input of people like Bell and Rymsdyk prompt us to reconsider patient-doctor models. We cannot ignore their agency and subsume it under that of their masters (even if Hunter thought of his assistants' work as his own). Existing conceptualisations of medical transactions do not allow us to account for artistic people like Bell and Rymsdyk. Hunter's case suggests we need to refine the notion of the transaction to include different kinds of medical agency and objectification.

Following on from the point about transactions, if case-notes have been deemed to objectify patients, then so did case-portraits. After all, they were products of a more literal medical gaze. They showed bodily fragmentations, not personal expressions. They obliterated a sense of time and space. Objectification by portraiture is very apropos for a doctor like Hunter, who built up a reserve of material-cultural deposits based on principles of figurative and literal objectification and sophisticated theorisations of objects and their display.[649]

Astley Cooper: portraits of patients or 'portraits' of diseases?

John Hunter's case shows how portraits were a way to put medical theories and principles into day-to-day practice. Yet his case-study also begs important questions. One particularly vexing problem that pervades medical portraiture like Hunter's is working out the extent to which the images can be said to be *of* patients or *of* the diseases afflicting them. In a recent paper, Mechthild Fend examined this patient-disease binary by looking at dermatological atlases of the early nineteenth century. She argues that these atlases fall on the disease side

[649] For more on this theorisation, see J. Hunter, *Directions for preserving animals, or the parts of animals* (1785). Hunter also taught these principles to his students. See Chaplin, 'John Hunter and the Museum Oeconomy', 104-6.

of the fence. This was mainly because, despite the use of some portrait tropes, the atlases' images did not engage empathetically with their subjects' exhibiting different diseases.[650] Sander Gilman has also referred to portraits of sufferers and patients as "image[s] of...disease[s] anthropomorphized".[651] Russell Maulitz's work on the "translation" of Xavier Bichat's morbid pathology into Britain also bears on this binary.[652]

In Hunter's case, I claimed that his patients' individuality was the main focus of each portrait's use and function. Yet Fend's, Gilman's and Maulitz's work – among others' – warns us that Hunter's focus ought not to be assumed to be usual. In other doctors' practices the focus might be shared or on something else altogether. The question then arises, how can we tell whether doctors focussed on people and/or on diseases? Indeed, how were portraits made differently to separate – or perhaps span – these two foci?

Material from the practice of Sir Astley Cooper is particularly helpful in dealing with these questions. I propose to examine portraits from his practice, bearing in mind a number of issues. I will consider how comparative the portraits were, and what the nature of any comparisons was. Portraits' arrangement, for instance, might offer clues about whether Cooper thought they were *of* similar patients or *of* similar diseases (or *of* both). His drawings allow us to re-query the roles of text and image. They also allow us to interrogate portraits' role in Cooper's ontology of disease, or nosology: how he used portraits to classify might indicate whether Cooper thought they were *of* patients or *of* diseases (or, again, *of* both). Similarly, the way in which Cooper's portraits subjectify and objectify his patients will be telling; I do not assume these principles were fixed. (The supposed objectivity of images has been much scrutinised by historians and sociologists of science. Bruno Latour, Lorraine Daston and Peter Galison have examined how images were presented as objective and also how images appealed to different conceptual

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650 M. Fend, 'Portraits of Patients or Portraits of Diseases? Nineteenth-Century Dermatological Illustrations', paper delivered to King's College London 'Medical Portraiture' workshop at the Wellcome Library, London, 26th May, 2012.

651 Gilman, *Disease and Representation*, 2.

652 R. Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (New York, 1987).

understandings of objectivity as time passed (see chap. IV).)[653] Again following quite directly from Hunter's lead, I will also consider how Cooper's portraits were used clinically within medical transactions and as records of medical transactions.

Cooper (1768-1841) was recognised as the preeminent surgeon of the first third of the nineteenth century.[654] His lectures inaugurated Thomas Wakley's *Lancet* in 1823. In 1784, he was articled to his uncle, William, at Guy's Hospital in London. He later transferred to the tutelage of Henry Cline at St. Thomas's. Under Cline, Cooper was schooled in Hunterian anatomy and surgery, although he would gradually err from Hunter's philosophically-minded teachings towards his own decidedly practical methods of anatomy and surgery (which he insistently kept separate). Ever the applied surgeon, Cooper became especially renowned for his dexterity, speed and precision. His manual skills were celebrated above his surgical theory. He was nonetheless a prolific writer who penned at least seven (favourably received) monographic treatises.[655] An affable and genial fellow, Cooper would develop a prestigious private practice in addition to his hospital duties;[656] he would include on his roster of patients Lord Liverpool, the Duke of Wellington and King George IV, who conferred a baronetcy on him in 1821.[657]

Scholars have noted Cooper's sensitivity to the visual in his medical practice. Druin Burch noted that Cooper's casuistry was advanced by meticulous observation: Cooper in fact declared that "observations on the diseased living, examinations of the dead and experiments upon living animals, are the only sources of true knowledge".[658] William Bynum, meanwhile, has noted that Cooper "paid particular attention to high-quality

[653] L. Daston and P. Galison, 'The Image of Objectivity', *Representations*, 40 (1992), 81-128; see also L. Daston and E. Lunbeck (eds.), *Histories of scientific observation* (Chicago, 2011).
[654] Besides an entry in the DNB, only two biographies have been written in the last two generations. R. C. Brock's *The Life and Work of Astley Cooper* (London and Edinburgh, 1952) was written by a Guy's medic to extol a Guy's medic's contribution to medical advancement. What it lacks in judgmental balance it makes up for with factual detail. Druin Burch's *Digging Up the Dead: Uncovering the Life and Times of an Extraordinary Surgeon* (London, 2007) is populist in tone and composition, and does not purport to offer a novel analysis of Cooper.
[655] His treatise on fractures, for instance, passed through six editions in the seven years between 1822-9.
[656] See Brock, *Astley Cooper*, 28ff. for a précis of Bransby Cooper's description of his uncle's mixed practice.
[657] DNB. For a list of the most important patients, see Brock, *Astley Cooper*, 41ff.
[658] Cit. Burch, *Digging Up the Dead*, 211.

illustrations, drawn by a succession of artists that he himself employed" for his publications (cf. chap. IV).[659] Despite such comments and despite Cooper's standing, scholars have paid no attention to the many drawings of patients and their morbid anatomy that Cooper made.[660]

I wish to make three arguments concerning the use and function of these drawings. First, they could exemplify diseases. They could literally stand as exemplifications of how diseases looked. Moreover, textual additions and various objectifying and subjectifying motifs could make these drawings both patient- and disease-oriented. They were *about* both diseases and individual patients' harbouring of diseases. Second, the drawings could be records of cases. Cooper's drawings recorded cases 'in progress', memorable cases, cases that bore witness to typical signs of diseases and cases that required particular surgical skills. Crucially, these different functional emphases affected whether the patient or the disease was focal. Third, unlike Hunter's drawings, Cooper's drawings were openly comparative. The physical arrangement of similar drawings affected their ontological status and tied them into Cooper's way of conceiving of diseases. This reveals again how portraits' meaning may emerge post-production.

Exemplifying drawings

In the preface to a book of drawings compiled in 1814, Cooper remarked that he had "in this book made a selection of such drawings to exemplify...different surgical complaints".[661] Cooper deemed his drawings to possess exemplary heuristic or classificatory potential. They helped to constitute his nosology. In this sense they showed not just illnesses but

[659] DNB.

[660] It is difficult to discern precisely who drew each drawing. Many that are signed are stylistically almost identical to others that are unsigned. Well over twenty draughtsmen signed at least one drawing. As Hunter's case demonstrated, precisely who made the drawings has historical and historiographical consequences. However, for ease and unless otherwise stated, I refer to Cooper's drawings as "his" even though I cannot be certain that he drew them.

[661] RCSEng MS0008/4/4, title-page.

medical knowledge too. One clue to this is the fact that Cooper would purchase drawings that he thought exemplified diseases. For instance, in 1841 he purchased from a Mr Taunton a drawing showing a typical *Morbid Growth of Intestine Producing Introsusception*.[662] Another clue is Cooper's artists' use of 'template' bodies. For instance, in five drawings that appear alongside each other, different diseased parts were drawn onto almost identical, nameless, classical, statuesque bodies (Figures 91-95). These impersonal, 'standard' (male)[663] bodies encourage the viewer to look beyond any surface specificity to the diseased part. Indeed, perhaps the contrast of surface perfection and inward imperfection and the confusion of surfaces – stone instead of flesh – encouraged such an inspective process. The use of such standardising models – which erase individuality – helps to suggest that diseases were the primary focus of such drawings.

As indicated by this sub-series, Cooper classified partly by the physical arrangement of his drawings. The drawings' ontological status alters as they are (re)organised into like examples. Indeed, likeness among Cooper's patient drawings implies those cases that are similarly exemplifying and emblematic of different diseases that attack different body parts. Body parts provide the classificatory focus. The purpose of looking at Cooper's patients' morbid anatomy, therefore, was to impart knowledge about how diseased body parts might appear. These drawings registered the typical look of a disease. Annotations could denote classifications. "Scirrhus" was a common annotation of Cooper's drawings of the breast.[664] Some drawings' titles give solely the names of the diseases they betoken: drawings of aneurisms are perhaps the clearest case in point.[665] Annotations also helped to *sub*-classify exemplary diseased parts. Hernias could be "strangulated", for instance. (Cooper in fact recognised thirteen varieties of hernia.)[666] The absence of such text, by contrast, suggests

[662] RCSEng MS0008/4/5/3, f. 289r.
[663] See M. Fend, 'Bodily and Pictorial Surfaces: Skin in French Art and Medicine, 1790-1860', *Art History*, 28, 3 (2005), 311-339, at 328-9.
[664] RCSEng MS0008/4/5/6, ff. 105ff. See below for discussion of some that are of named patients.
[665] See the cases of aneurism of the aorta, RCSEng MS0008/4/4, ff. 119, 121.
[666] A. P. Cooper, *The anatomy and treatment of Abdominal Hernia* (1827), 1-2.

that diseases were rather evident: plain drawings could encapsulate the look of a disease without a textual prompt: many drawings of hernias bear this out, too.[667]

So if drawings could encapsulate the look of a disease, did they ignore patients? Are these drawings, taken together, evidence that Cooper believed that diseases were independent of the patients that suffered from them? The short answer is, not necessarily. Although certain drawings, like those which used the statue template, were of obviously anonymous bodies, too many of the drawings that show diseased parts included individuating features for us to conclude absolutely that diseases were independent of a patient's individual circumstances. There are many clues in the very quality of the drawings that suggest Cooper focussed on patients as well as diseases.

For one thing, Cooper insisted (much as Hunter did) on accurate depictions of people, not just diseased parts. He admitted when individual likenesses were not faithful, even if they did not affect the representation of the patient's morbidity. For instance, a drawing "of a Cast in my possession shewing the double hare lip...gives too much age to the person as he was young."[668] His artists also paid attention to clothing: Mr Tucker's yellow stockings, Elizabeth Loive's blue shawl, and John Adams' red head-cap are three examples of artistic effort that would have been otiose if the disease were all that Cooper cared about (Figure 96).[669]

Second, diseases or diseased parts that manifested themselves outwardly necessitated a decision about whether and how to depict a patient's features – especially when the disease was located on the patient's face. (This problem was not unique to Cooper, as we shall see especially when we discuss military patients' portraits below.) In these portraits, Cooper paid attention to patients' individuating features as well as the diseased portion. Granted, more attention was paid to the diseased portion. Granted, patients' skin was often rendered un-naturalistically, often remaining as the surface of the

[667] RCSEng MS0008/4/5/3.
[668] RCSEng MS0008/4/4, ff. 22-3.
[669] RCSEng MS0008/4/5/5, f. 777; *ibid.*, 4/5/6, ff. 105r-v, 319r.

paper or card on which the portraits were drawn.[670] All the detail – and colour – of Joseph Silvester's portrait, for instance, is condensed into the watercolour depiction of his nasal tumours; his eyes, hair, mouth and chin are executed lightly and quickly, and contain detail and tone only in the strength and thickness of the pencil lines (Figure 97). The same (im)balance of artistic effort can be seen in George Thomas', William Deane's and Joseph Marner's portraits – although the contrast of watercolour and pencil depends on how much of the page the diseased portion takes up.[671] But the overall point to be made here is that patients' likenesses and features were not at all ignored. They were not faceless forms erased of person-hood. Indeed, visually speaking, the diseases were yoked to the specific patients that suffered from them.

Third, if individuation occurred through the depiction of features, Cooper also identified the patient-source of the disease through titles and annotations. His classification process included specifying individual patients. Indeed, the blend of image and text indicates that the patient was the focus as and when he or she was named. Annotations often detailed patients' names and peculiar – crucially personal – clinical information. Titles could contain both the name of the disease *and* the name of the patient exhibiting the disease, such as *Fungus Oculi Williams see Case*, or *Calculus with enlarged Prostate Revd Mr Hood – died from operation*, or *Aneurism Sir C Scudamore*.[672] And where a title referred only to the disease suffered, annotations could supply further details, including names and histories, as for instance in the case of Joseph Marner's *Cancer of ye Upper Lip* (Figure 98).[673]

Artistic techniques like capturing individual features and clothing, portraying patients in a pose that allows the viewer to see their faces, and putting a name to them – all increase the subject-hood of the drawings. (It is another thing to determine which of these devices does this most.) Significantly, drawings of patients that suffered from certain

[670] With this, cf. Fend, 'Bodily and Pictorial Surfaces'.
[671] RCSEng MS0008/4/4, ff. 2-3, 4-5, 240-1, 242-3.
[672] RCSEng MS0008/4/4, ff. 45, 145, 85.
[673] RCSEng MS0008/4/4, ff. 240-1.

diseases in certain body parts – like diseases of the breast, or calculi, or those that affected the face (hair lips, eye and nose complaints, cranial tumours and so on) – bear more subjectifying marks than drawings of other diseased parts. Indeed, I would go as far as to say that Cooper conceived of diseases of certain parts as more subjective than other parts. Kidney stones were the subject of particular medical attention throughout the long eighteenth century.[674] Cooper also recognised the subjective importance of the breast – especially in motherhood, for instance.[675]

All of these points lead me to say that Cooper's nosological specificity – his rigour and precision in identifying and sorting diseases, if you like – derived from the specificity of his patients' suffering. It mattered to Cooper who was suffering and what the manifestation of the disease looked like on each patient. Portraiture was a way of 'ratifying' this specificity.[676] A portrait made the manifestation of each disease in each patient even more precisely classified. In this way, then, Cooper's drawings were portraits of both patients *and* diseases. This very linkage of patient and disease in portraiture was crucial to Cooper's efforts to increase his understanding of diseases. Moreover, this individual specificity mattered more to those body parts that Cooper thought were more subjective.[677]

Overall, it seems that portraiture was a means purposefully to combine the classificatory potential of diseases and patients. And drawings and text had different but complementary representational roles in depicting what was suffered, where on the body, and by whom.

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[674] Their size in particular was a common topic, and engravings of the biggest and most fabulous stones were widely sold. Portraits of Nicholas Byfield, the seventeenth-century vicar of Isleworth whose autopsy revealed a bladder stone 18" x 13", were still being published as late as 1790: WL 209i. Moreover, people paid princely sums to lithotomists: William Cheselden earned fame and fortune for cutting for the stone, and Cooper himself once earned 1000 guineas from a single operation: Brock, *Astley Cooper*, 39.

[675] A. P. Cooper, *Illustrations of Diseases of the Breast* (1829), 3.

[676] With this, cf. Lam Qua's portraits of patients; Gilman, 'Lam Qua and the development of a westernized medical iconography', 63.

[677] See below for more discussion of the importance of body parts to Cooper's comparative method.

Portraits of patients that betokened different diseases were taken at various points in the cycle of a patient's case and in the progress of a disease. Just as they did for Hunter, the portraits suggest that they were used to remember cases. For Cooper, I argue that this memorial function served four aims, each of which had a bearing on whether a portrait was more disease- or patient-centric. First, I argue that they were immediate clinical records (and thus more patient-centric). Second, I argue they recorded memorable cases (and were therefore patient-centric). Third, I argue they inscribed the signs of different illnesses at different stages (and were in this respect more disease-centric). And fourth, I argue that they recalled operational procedures (and could therefore be equally patient- and disease-focussed). Implicit in these arguments is the claim that they *were* clinical, but did not *contribute* to the direct provision of medical care to any particular patient. Also implicit is the argument that, if different aims affected how disease- or patient-centric portraits were, then we should hesitate to talk about a patient-disease binary; in other words, the dichotomy is unwarranted.

Cooper declared his observational method to rely on inspecting patients at various points in their cases. His drawings marked those stages. Indeed, he "had numerous drawings made of them [patients] at the time of the inspection of [their] bodies".[678] Taking drawings at the very point of clinical inspection means they testified to the look of diseases at the time a patient presented and was treated. Cooper noted that William Deane's tumour of the lip was "*now* a very formidable appearance, as the Drawing opposite represents."[679] The swelling of poor three-year-old Andrew Griffin's eye "continued to increase *until* it assumed the appearance which the Drawing represents" (Figure 99).[680] In each case, the drawings were immediate, present-tense records of the look of a disease at a given point in

[678] RCSEng MS0008/4/4, title-page.
[679] RCSEng MS0008/4/4, ff. 240-1. Emphasis added.
[680] RCSEng MS0008/4/4, ff. 40-1. Emphasis added.

time and at a certain point in its progress. In other words, they showed the look of illnesses.

Many drawings were sketches, not 'fair-copy' illustrations. No time was spent on extraneous details. Take Mrs Dodd's (Dodds'?) case of A *Disease of ye Popliteal Nerve* (Figure 100). Her leg is portrayed with almost cartoon-like simplicity, whereas the integuments are depicted with minute precision; all the attention is focussed onto the diseased portion beneath the skin's surface that is crucial to the case.[681] The circumstances of production also suggest that drawings met clinical demands. Sketches were taken by whoever happened to be present at the patient-doctor interaction. At least 23 artists made drawings for Cooper.[682]

Such sketches could be the first description of a case. Time and again, Cooper made first recourse to visual media. Text supplemented them. Explanatory case-notes *surround* drawings of the breasts of "Mrs Fuller aged 73" and of a Mrs Voltinger.[683] Case notes were written *beneath* the small pencil portrait sketch of William Fox, who presented with cancer of the eye (Figure 101).[684] In Elizabeth Loive's case in 1829, "the notes...and drawing furnish the history".[685]

As well as providing immediate records of the appearance of patients' afflictions, drawings could act as *aides memoire* – mainly of memorable cases that stuck in Cooper's mind.[686] The case of Jobson Wallace, a patient at St. Thomas's, stuck out for being similar to chimney-sweep's cancer; it was also noted that Wallace "outlived the time of the drawing about 5 or 6 months [and] became much worse in appearance".[687] The case prompted a reminder comparing the disease with another disease *plus* a comment reminding the viewer

[681] RCSEng MS0008/4/5/3, f. 390r.
[682] That said, certain artists did seem to draw more than their fair share of certain diseases: John Hume drew more of the breast (and nipple) than anyone else; George Kirtland most often signed drawings of hernias
[683] RCSEng MS0008/4/5/6, ff. 137r, 141v.
[684] RCSEng MS0008/4/5/8, f. 505.
[685] Averill to Cooper, 3rd March 1829, RCSEng MS0008/4/5/6, f. 165ff.
[686] For an example of a case "deemed so singular, that a portrait of the man [Nicholas Byfield again] was engraved", see Caulfield, *Remarkable Persons*, 158.
[687] RCSEng MS0008/4/5/5, f. 296v.

about the specifics of the patient's case. The only recorded reason for a drawing of Miss Brooks' ovarium was that Cooper had operated on her four years before she died.[688] The drawing of Cooper's most prestigious patient warranted the annotation that "King George ye 4th['s] Tumour [was] removed [in] May 1821" (Figure 102).[689] Note that these comments could remind Cooper of patient- as well as disease-specific information.

On many drawings, Cooper wrote up memoranda on surgical procedure in order to remind himself – or any other reader/viewer – of what could be seen and how he had operated. In the care of a common hare lip, the edges were "pared off with a Lancet and two sutures...used".[690] In the case of 22-year-old Mrs Soper's gangrene:

> The sides of ye wounds were brought together & adhered & ye girl was cured...2 A portion of ye bodies in seen composed of a solid substance...covered by a capsule adhering to ye solid.[691]

These reminders would presumably inform later cases. If so, these drawings serve as excellent examples of how a strategy within portraiture (i.e., annotation) can affect direct medical practices.

Other drawings were made specifically to record the signs of certain illnesses. A case drawn by Cooper's pupil John Burnall showed *A Portion of Lungs from a Person who died suddenly from water in the Chest*.[692] Burnall noted that the "spots are the principal marks of disease under such circumstances". Here, the signs of disease are yoked to the specific circumstances of the patient, even though that patient was unnamed. Similarly, the case of Mrs Edge's *Scirrhus of Lungs* was notable for its "yellowish"-ness.[693] In each example, the

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688 RCSEng MS0008/4/5/5, f. 310v.
689 RCSEng MS0008/4/5/5, f. 317r.
690 RCSEng MS0008/4/4, ff. 12-3. With it, cf. *ibid.*, ff. 14-5.
691 RCSEng MS0008/4/4, ff. 2-3.
692 RCSEng MS0008/4/5/3, f. 338r. For Burnall as Cooper's pupil, see *ibid.*, 4/5/5, f. 309r.
693 RCSEng MS0008/4/5/3, f. 334r.

illness was the focus of interest, whether the patient's name was noted or not. But that focus was sharper when peculiar circumstances brought about peculiar signs of illness.

Given their purpose, it was crucial that these records were accurate. John Holt noted of one of his sketches for Cooper that "this sketch was made in great haste, and by candle-light; consequently it is extremely bad as a drawing but I believe the most essential features, in an anatomical point of view, will be found correct."[694]Holt was explicit about the "anatomical point of view" that would come to scrutinise his drawing. It is possible that Holt was disclaiming against imprecision in his method so that Cooper – the intended viewer – would not allow his eyes to be deceived by Holt's imperfect draughtsmanship.[695] Other examples indicate the importance of recording the signs of illness as rigorously as possible. A black and white drawing of Mr Currie's hernia was re-drawn in full watercolour and accompanied by a more copiously penned history.[696] Annotations also note when standards of accuracy slipped: Cooper annotated a drawing of Jobson Wallace rather critically, noting that

> The slit [is] rather too long at bottom. The whole [is] too large – Penis too large and long...[the] outline of [the] Thigh [is] too near...[697]

So Cooper's drawings, like Hunter's, served both an immediate analytical function as well as a later 'memorial' function. This allowed them to be compared. Let us explore how they were compared and how this contributes to our understanding of Cooper's medical showing and looking.

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[694] RCSEng MS0008/4/3, 6th slip.

[695] On eradicating personal error for the benefit of others in scientific analysis and recording, see S. Schaffer, 'Astronomers Mark Time: Discipline and the Personal Equation', *Science in Context*, 2 (1988), 101-31. Cf. chap. IV.

[696] RCSEng MS0008/4/5/3, ff. 296-7.

[697] RCSEng MS008/4/5/5, f. 296v. Annotations could also be positive. Many of Cooper's inscriptions bear the hallmarks of feedback on his pupils' drawings. E.g. MS008/4/5/3, f. 314.

Unlike Hunter, who seems to have treated people on a case-by-case basis, Cooper avowed a decidedly comparative method. As Cooper explained in his *Surgical Essays*, "how much additional value the relation of an ordinary case acquires when supported and illustrated by others nearly resembling it, is too obvious to require exemplification."[698] For instance, in a case of a nasal tumour, Cooper compared Joseph Silvester's mere "growth of skin" with "a similar operation...performed upon a Mr Peacock in Leadenhall Market" and also recalled that "Mr Graham had one on each side".[699] (Cooper also taught his students by comparison.)[700]

Drawings were central to this comparative casuistic method.[701] Cooper had a drawing made of George Thomas, who presented with a tumour on his lip. Cooper thought fit to juxtapose Thomas' portrait with a section of a tumour taken from a comparable case, that of "Mr Tewhurst of Hawkhurst, Herts".[702] Similarly, the drawing of the hare lip and jaw of one Mr Nowe of Somers Town was paired with "a similar case in Mr Van Hey Heusen's child [in] Bedford Row."[703] Drawings were Cooper's means of comparing visible life histories with post-mortem appearances. They charted the look of diseases not only at different points in time, but also among different patients' cases. Cooper compared between cases, not necessarily just 'within' the same case. He even compared his cases with those of other doctors: he juxtaposed two polypic noses "from Mr Cline's practice" and "from Mr Bury's patient at Reading" with two of his own patients, a Mr Daunton and a Mr Vanons.[704]

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698 A. P. Cooper, *Surgical Essays* (2 vols.., 1818-9), i, xii.
699 RCSEng MS0008/4/4, f. 1.
700 See R. C. Brock, 'The Life and Work of Sir Astley Cooper' (the 1968 Astley Cooper oration), 6.
701 This stands for his published work as for his pre-publication clinical practices. I focus on the latter here.
702 RCSEng MS0008/4/4, ff. 4-5.
703 RCSEng MS0008/4/4, ff. 24-5.
704 RCSEng MS0008/4/4, ff. 28-31.

The comparative method is played out in the arrangement of the drawings, too. The physical arrangement suggests that, as far as comparisons are concerned, diseases took analytical precedence over patients. All the volumes juxtapose similar cases as closely as possible. In the 1814 volume, all the cases of hare lips appear consecutively. Drawings of (unnamed) patients with eye complaints follow them in an unbroken line. Two cases of aortic aneurism also appear side-by-side. Some drawings even refer to drawings elsewhere in the volume: commenting on the case of hare lip in Mrs Sheen's daughter, it struck Cooper that "the skull in the succeeding case appears to be a similar case in the adult."

The drawings compiled into five further volumes were organised by body-parts – the seats of disease. Just like in the making of exemplifying portraits, Cooper's arrangement also suggests that he afforded a certain analytical priority to diseases as they affected different areas of the body. In his *Illustrations of Diseases of the Breast* (1829) Cooper noted that "comparison...assists the surgeon in forming a diagnosis of the various complaints to which *any organ of the body* is liable."[705] The analytical priority of disease by body part is also noticeable in the drawings; patient identification was not a pre-requisite for comparison.[706] Drawings of the breast and nipples, for instance, comprise different views of that part, from identified and unidentified patients (see Figure 103). Aligned on the same page, they together constitute a detailed chart. Importantly, most of the drawings are of a comparable size, colouring and labelling – but they are not uniformly labelled. Some merely contain the sex and age of the sitter. Any 'anomalous' drawings could be picked out by visual differences; the patient's name would not necessarily be on them. Drawings of hernias are another example. They comprised both internal and external views and were also arranged sequentially. Moreover, in all the volumes, big gaps were left, presumably so that like cases could be (literally) drawn in or pasted in as and when they occurred – i.e. to continue the sequence of disease by body part. Drawings of eye complaints and skin diseases are two

[705] Cooper, *Illustrations of diseases of the Breast*, 1.
[706] E.g. RCSEng MS0008/4/5/8, f. 624.

examples of sets that are followed by many blank leaves.[707] Although the fact that the volumes contain a combination of drawn-in and pasted-in drawings means that they were not arranged together from the start, their subsequent arrangement typifies the principle of comparative surgery that Cooper continually espoused. It also exemplifies how their medical significance could emerge after they were made.

Interim conclusions

Cooper's practice, like John Hunter's, was full of portraits (be they of body fragments or whole bodies, be they named or unnamed). Indeed, taking the two case-studies together, we can begin to compile a rather lengthy list of the uses of portraits and to see how intrinsic they were to various medical endeavours. There are broad similarities between Hunter and Cooper. Both doctors employed assistants, generating complicated clinical transactions. Both used text to adorn images – for different ends although on a similar mutually reinforcing basis. Yet there are peculiarities. Cooper was not as involved in sharing portraits as Hunter was. Hunter did not assemble together and compare his portraits like Cooper did. These peculiarities relate to the doctors' distinct medical methods – of observation, of diagnosis, of comparison, of acquiring medical knowledge and so on.

Cooper's case has also shown that the analytical focus of portraits could change according to the uses they were put to. Certain functions rendered portraits more 'about' patients or 'about' diseases. This should not lead us to think of patients and diseases as opposites, for portraits could combine patients and diseases together analytically. Exemplifying portraits, we recall, could focus on diseases, or both diseases and patients. The difference there lay in the portraits' precise production: portraits gained meaning by how they were made to be used as well as by their eventual 'emergent' analytical focus. So we should not imagine any patient-disease dichotomy to be inherent in portraits of patients

[707] E.g. RCSEng MS0008/4/5/8, f. 611ff..

(or other classes of medical imagery). Patients and diseases were not always analytically immiscible.

Cooper's case has also revealed how portraits can reveal aspects of his practice as a doctor (by which I mean *qua* doctor). They reveal what he thought portraits could do for his practice – like help to constitute histories. Portraits disclose how he broke down – nay, how *they* broke down – diseases into different sub-categories, like "strangulated" hernias. In these sorts of ways, portraits of patients can advance historians' work on doctors as well as on patients themselves.

Portraying to a plan: John Thomson's and William Somerville's Waterloo portraits

We have seen how portraits could be used on an *ad hoc* basis to serve a number of functions within two doctors' practices. The portraits examined in the chapter so far were the products of doctors' artistic sensibility to be sure, but also of specific circumstances: they were taken in hospital wards or patient rooms, with assistants and pupils on hand to make them, and with time to annotate and maybe arrange them. I would like, therefore, to consider some portraits that were made under entirely different circumstances: a commissioned medical data-gathering mission undertaken in the aftermath of war. Was the production and function of patient portraits similar under these extreme conditions? The experience of Messrs Thomson and Somerville after the Battle of Waterloo in 1815 provides a good test case.

The price of peace following Waterloo was counted in wounds and scars as well as lives and pounds. Soldiers of the Napoleonic Wars suffered all manner of injuries advancing towards musket balls, cannon balls, grapeshot, bayonets, sabres and lances.[708]

[708] This is not to mention the scourge of infectious diseases, like plague (immortalised in Antoine-Jean Gros' 1804 portrait of Napoleon visiting the plague-stricken at Jaffa) or "Walcheren" fever, which was rife among the British in 1809-10. On the latter, see M. R. Howard, 'Walcheren 1809: a medical catastrophe', *British*

Military surgeons were on hand to tend to and operate on the worst wounded. Some made portraits of the patients they encountered there. Historians are reasonably familiar with Charles Bell's Waterloo portraits, for instance.[709] But a large series of portraits made by John Thomson and William Somerville has received scant attention.[710]Their portraits, made to make sense of the wounded soldiers' cases, both for themselves and for others, document how art can capture a patient's look and render physical wounds medically intelligible.

Thomson (1765-1846) began his medical life as a pupil to John Hunter. He attended Hunter's classes in Leicester Square. His exposure to military medicine was triggered by an appointment as a mate in an army hospital in 1803 – a conscious appointment designed to improve his knowledge of military medicine. In the same year, he delivered a course of lectures on military medicine to students at the Royal Infirmary in Edinburgh. His expertise was recognised by his appointment to the Regius chair of military surgery in Edinburgh University in 1806.[711] Importantly, his visit to the hospitals of Belgium was not his first trip to Europe. He had been on a lengthy tour of hospitals in France, Italy, Austria, Saxony, Prussia, Hanover and the Netherlands only a few years before. In Paris, he met, among others, Drs d'Alibert and Esquirol.[712] He inspected their drawings and collections. He visited the St. Louis and the Salpêtrière hospitals, interviewing patients as he passed through.[713] He also bought "some old books on G. S. Wounds".[714]

Medical Journal, 319, 7225 (1999), 1642-5. On war and medicine generally, see C. Kelly, *War and the Militarization of British Army Medicine* (London, 2011).

[709] See M. K. H. Crumplin and P. Starling, *A Surgical Artist at War: The paintings and Sketches of Sir Charles Bell 1809-1815* (Edinburgh, 2005) – although their book does not purport to take account of art historical analysis of Bell's work – and M. R. Howard, 'British Medical Services at the Battle of Waterloo', *British Medical Journal*, 297, 6664 (1988), 1654. As I write, Brendan Clarke and Chiara Ambrosio from UCL are preparing a study of some recently discovered images by Bell.

[710] They got the briefest passing mention in M. H. Kaufman, *Musket-ball and Sabre Injuries from the first half of the nineteenth century* (Edinburgh, 2003), 61 and in P. Stanley, *For Fear of Pain: British Surgery 1790-1815* (London, 2003), 121. But no-one has analysed them in any depth. For convenience, I refer below to Thomson as the main artist.

[711] DNB.

[712] NLS MS9235, ff. 11v, 16r.

[713] NLS MS9235, ff. 11vff.

[714] NLS MS9235, f. 19r.

Later on his tour, in Vienna, Thomson got an even clearer preview of what he would witness in Belgium: "among the many injuries there were many instances of reunion of detached portions of both tables of the bones of the head in sabre wounds, and one very remarkable example of the reunion of a great number of fragments of the os frontis which had been occasioned by a musket ball which had entered the left temple, and passed out above the interior angle of the right eye."[715]

William Somerville's (1771-1860) career was inextricably bound to the army, although he is perhaps best remembered nowadays as the husband of mathematician Mary Somerville.[716] William entered service as an army hospital assistant in 1795 before graduating M.D. from Aberdeen in 1800. He was assigned to General Sir James Craig, first as garrison surgeon in Cape Town, and latterly as inspector general of military hospitals in Canada. After Craig's death, Somerville returned to Britain, where he rose from being deputy inspector of hospitals in Portsmouth to become the head of the army medical department in Scotland in 1813. He was finally appointed one of the principal inspectors of the army medical board in England.

In July 1815, Thomson and Somerville travelled to British military hospitals requisitioned in and around Waterloo.[717] Besides being skilled practitioners in a place where skilled practitioners were needed, and besides being excited by the unique opportunity to learn about practical military medicine,[718] they were there on the recommendation of Dr James Mcgrigor, Head of the Army Medical Department. Mcgrigor commissioned them to pen a report on the state of the wounded post-Waterloo and on the state of military

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[715] NLS MS9235, f. 32r. He also visited the Josephinum Academy and inspected the anatomical preparations of Prof. Prochaska; *ibid.*, f. 32v.

[716] DNB; Munk, *Lives of the Fellows*, iii, 168.

[717] The circumstances of their voyage are briefly glossed by M. H. Kaufman, *Surgeons at War: Medical Arrangements for the treatment of the Sick and Wounded in the British Army during the late eighteenth and nineteenth centuries* (Westport, CN and London, 2001), 103-4.See also *idem*, *Musket-ball and Sabre Injuries*, 61. Kaufman commented (*ibid.*) that the portraits I shall discuss included brief legends, but he also claimed (erroneously in my opinion) that they did not include clinical detail.

[718] J. Thomson to M. Thomson, 12th July, 1815, NLS MS9236, f. 57r. Thomson was not the only one excited: he noted that Astley Cooper sent over his nephew and an assistant to collect cases (*ibid.*, f. 58v).

medical provision 'in the field'.[719] They were there to observe, survey and report back. Among those Thomson and Somerville teamed up with were surgeon's mate John Davey and assistant surgeon Donald Finlayson, whose correspondence has benefitted military historians.[720] Thomson and Somerville visited at least eleven hospitals.[721] The hospitals were chock-full of wounded men. Davey wrote that "every place was occupied...so that it was difficult to walk even in the passages without treading on [the wounded]."[722] Thomson commented on the "the worst cases of 2000 wounded" at Antwerp.[723] His report later commented that British doctors were caring for "perhaps the most wretched beings that were ever left on a field of battle".[724] There was a constant stream of men to attend to. The doctors worked from "brickfast to dinnertime" on most days.[725] And by 25th July, Thomson wrote to his wife, Margaret, that he had "seen above 400 cases".[726]

The report seemingly provided the impetus for making portraits of wounded patients. The portraits were taken in a large sketchbook, the original binding of which is identical to the binding of the manuscript report.[727] Even if sketchbook and report were not tendered together – and there is no evidence that the sketchbook was ever tendered to anyone – it does appear that they were produced side-by-side and that the portraits informed the overall clinical assessment of the wounded. Indeed, the sketchbook comprises portraits taken on the spot of 176 patients. They are arranged by the type of wound inflicted *and* by the part of the body which was wounded. This corresponds almost exactly with the structure of the report:

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[719] Ed. Uni. Lib. E62/44 Gen. 595D – hereafter "*Report*".
[720] See e.g. http://www.1815.ltd.uk/site/correspondence/british/donald_finlayson.php; accessed 22nd June 2012.
[721] *Report*, 10, 12.
[722] J. Davey to Mrs Fletcher, 26th July, 1815, NLS MS9236, f. 68v.
[723] John Thomson to Margaret Thomson, 12th July, 1815, NLS MS9236, f. 58v.
[724] *Report*, 3.
[725] John Thomson to Margaret Thomson, 3rd July, 1815, NLS MS9236, f. 55v; same to same, 15 July 1825, *ibid.*, f. 60r.
[726] John Thomson to Margaret Thomson, 25th July, 1815, NLS MS9236, f. 65v.
[727] Ed. Uni. Lib., E62/43 Gen. 594 (B 164) – hereafter "*Sketches*". The *Report* and the *Sketches* manuscripts exist side-by-side in Thomson's papers.

> Wounds have been distinguished...from the form of the weapon with which they are inflicted, and from the region of the body in which they occur. To the first division belong incised, punctured, contused, lacerated and gun-shot wounds; to the latter, wounds of the head, face, neck, chest, belly, and extremities...[728]

It is worth bearing this structure in mind when we come to read clinical annotations that elaborated on a soldier's name, regiment and hospital.

Some 47 of the 176 portraits, just over a quarter, were of patients with facial wounds – and it is these that I shall focus on. Indeed, as already implied, Thomson and Somerville categorised these separately in the sketchbook – as 'Wounds of the Head, Face and Neck'.[729] I focus on these because they will offer powerful insights into how the genre of portraiture was adapted to extreme clinical demands. How, for instance, was facial likeness handled with such constraints on time? How did annotations supplement portraits as the sole clinical record of soldiers' medical experiences?[730] How may we analyse the interaction of text and image when portraits informed a textual account but were not presented along with it? Finally, how did portraits manage the ethical implications of looking at people who, as Thomson later reported, "presented very frightful appearances"?[731]

I argue that the sketches (plus annotations) were for Thomson and Somerville, just like for Hunter and Cooper, the chief means of understanding the medical issues in front of them. The pair developed an extremely efficient and economical mode of taking portraits that conveyed as much information as they needed with a minimum of artistic effort. This mode rendered portraits variably individualising according to the nature of the wounding. I then argue that the portraits reveal how the artists did not sacrifice accuracy at

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[728] *Report*, 26.
[729] *Sketches*, Index.
[730] There is one exception: Moses Wyse's case was written up at length for the final report. See *Sketches*, f. 13, and case "no. 2" of the *Report*.
[731] *Report*, 26.

the sight of grievously wounded people, but that the 'look' of the portraits *was* affected by how the artists looked on the soldiers. Finally, I argue that comparing the annotated sketches and the final report shows how text and images revealed different information to, and were accessible for, different recipients. Images were simply immaterial to the final report. This point again suggests that their primary function was clinical and 'in the moment'.

Portraits as efficient clinical records

Thomson's sketches of faces and heads were drawn quickly. He used an ink pen. None has a background. In the majority of portraits, only outlines are shown. They were often incomplete. Features were added only in certain cases. Features were obviously portrayed if they constituted the wounded portion. But it seems that Thomson depicted relevant facial features primarily so that the wounds could be situated in relation to them. As such, features were often superfluous; they were necessary only inasmuch as they helped explain the wound. The eyes were omitted in the portrait of François Chapuis, who suffered a sabre wound to the head (Figure 104).[732] Alexander Kirkland, who suffered a fractured skull from a sabre strike, was portrayed with no mouth (Figure 105).[733] In these two examples, the omitted features were irrelevant to the wound. The profile portrait of François Guillaume shows how "A musket ball entered immediately behind the left Ear".[734] No other feature besides the ear was depicted. Similarly, in the case of Edwards at the Jesuit Hospital, a "musket ball...[had] passed out through the hollow under the lower lip". The lip was sketched accordingly.[735] Shoulders were only depicted to show exit wounds in

[732] *Sketches*, f. 31.
[733] *Sketches*, f. 26.
[734] *Sketches*, f. 42.
[735] *Sketches*, f. 49.

the neck or back.[736] Joseph Holleran was shot in the maxilla, and the musket ball "came out on the right side of the cervical vertebrae".[737] The case of M. Sanges was all but identical to Holleran's. So is the portrait; it would be exceedingly difficult without the accompanying annotation to distinguish between the two soldiers (Figures 106 and 107).[738]

If the situation of the wound determined the features that the portrait showed, then it also determined the pose. The sketches were taken from all manner of positions according to the where the wound was. Men slashed from behind were obviously portrayed from behind.[739] Robert Stubley was portrayed lying down from about the position of his waist, so that Thomson could see the ball holes in his neck, beneath the jaw.[740] Thomson caught another anonymous soldier who had been shot through the gullet in exactly the same pose as Stubley.[741]

Only two soldiers were portrayed in more than one pose – i.e. whose portraits contain two 'figures'. Again, this decision related directly to the depiction of the wound: the two men suffered wounding from musket balls which came in and went out through opposite points of the head. "Lt. Col. Brown of the 79th regt was wounded by a musket ball which entered the right cheek at A Fig. 1 passed through the mouth, fractured the Jaw, partially dislocated it, & came out at B Fig. 2.". The ball which struck Evan "entered right Maxilla at A. Came out at B Fig 2nd on the right side of the cervical vertebrae".[742]

Profiles were also sketched in varying degrees of detail. It seems that portraits depicted more individualising features when Thomson noted more complicated symptoms, sometimes beyond the simple suffering of the wound. The features depicted did not always relate to the symptoms, however. It is just that clinical complexity seems to have led to more time being spent on the portrait, and therefore to greater patient individuality. They

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[736] The one notable exception is perhaps M. Tertogande; *Sketches*, f. 35.
[737] *Sketches*, f. 51.
[738] *Sketches*, f. 56.
[739] E.g. *Sketches*, ff. 28-30, 32.
[740] *Sketches*, f. 39.
[741] *Sketches*, f. 40.
[742] *Sketches*, ff. 47, 55.

commanded more time. This is to say, patient portraiture gained in detail when it recorded more clinically complex cases.[743] By clinically complex, I mean those about which Thomson thought there was more to reveal. William Ryan was shot by a musket ball which – in Thomson's common formula – "entered A. Came out B" (cf. Figures 106-108). But Ryan's portrait also shows and refers in the annotations to his blinded left eye: "Left eye injured & blind. Both eyes affected." All his features are shown, and some wispy hair falls from the top of his scalp (Figure 108).[744] M. Furrier's profile also shows all his features; the musket ball he suffered also "splintered the teeth".[745] John Luin, whose profile is complete, also suffered lost teeth and a splintered jaw.[746] Herr Schlem's profile is also complete; his portrait precedes the annotation that, having been shot in the throat, he was remarkably hoarse.[747] Finally, Lt. Pagan's profile sketch includes a full crop of hair and a boldly portrayed iris. Thomson noted his suffering at some length (comparatively speaking):

> Lieutenant Pagan of the 33rd regt very close to the evening was struck by a nine pound cannon ball which shaved his ear close off. He had been deaf before the wound and became more so. Great purulent discharge from the Ear....He suffered much from Headach...[*sic*].[748]

So portraits could encompass – and depict – a great range of clinical complexity, and could accordingly be made with various levels of detail. This is a general comment; and the material supplies an exception to this rule. Sgt. Davies portrait was taken from behind and depicts only his right ear. Yet the annotations read that the musket ball that struck Davies had lodged itself in the "substance of the Brain" and "Epilepsy & other bad symptoms

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[743] By this I do not mean that a case was more challenging, but simply that Thomson felt there was more to reveal about it.
[744] *Sketches*, f. 43.
[745] *Sketches*, f. 52.
[746] *Sketches*, f. 54.
[747] *Sketches*, f. 38.
[748] *Sketches*, f. 57.

ensued. He was copiously bled by Mr Wilmore & on removing the piece of bone Epileptic symptoms ceased."[749] Here were detailed annotations to a detailed case with a plain and simple portrait sketch. Overall, however, the trend holds. Greater complexity prompted more annotations and a more complicated sketch. Simpler cases warranted very quick portraits that conveyed the basic clinical details clearly and without ornament. This allowed Thomson and Somerville to see as many of the five thousand-odd men as they could without going into unnecessarily minute detail.[750]

Managing ethical implications of wounding and looking

In her work on surgical artist Henry Tonks', Emma Chambers suggested that Tonks engaged in his war-wounded sitters' sense of fragmented identity; Chambers argued that Tonks' 'after' portraits amounted to an "artistic reconstruction of identity" that recognised the importance of the integrity of the skin to soldiers' rehabilitation.[751] There is little to say that Thomson and Somerville engaged with their sitters' identities to anything like the same degree. Notwithstanding any personalising details, these portraits, taken as a batch, do not verge at all on the sentimental. Even the anonymous soldier slashed across the mouth and nose was portrayed utterly straight-faced.[752]Despite Thomson's noting that facial wounds gave "much distress, by the pain, the deformity and the injury to the organs of sense", evocations of pain are decidedly absent from these portraits.[753]It would be rash, for instance, to infer from their slightly bowed heads that these soldiers were dejected.[754]The only portrait that even suggests a soldier's discomfort is Robert Stubley's. This exception, coupled with the evidence of the overwhelming majority, further evinces that these

[749] *Sketches*, f. 23.
[750] For this aim, see *Report*, 10-12, 280-1.
[751] Chambers, 'Fragmented Identities', 597-8.
[752] *Sketches*, f. 34.
[753] *Report*, 63.
[754] See e.g. the portrait of Thomas Rease and Lt. Col. Brown, *Sketches*, ff. 14, 47.

portraits were made as dispassionate clinical documents. It is as though the portraits were emotionally neutral templates onto which the medical record (of the wounding and the annotations) was superimposed.

Two types of example, however, add nuances to this otherwise bold and colourless picture. The first is frontal portraits. Intriguingly, frontal sketches – posed at an angle that at least showed both eyes – gave rise to the most detailed portraits of the whole batch, no matter the complexity of the case. If profiles might be labelled schematic and discernibly different only by the site of the soldiers' wounds, then Thomson's frontal sketches were decidedly more personalising, far more sensitive to individual features. To begin with, almost every frontal sketch depicts the soldier's hair.[755] Some locks are thick and well-defined, such as Angus McKinnon's or James McNulty's.[756] Others' hair is wispier, like M. Froctront's (Figure 109).[757] Thomson also paid greater attention to the noses and lips of those soldiers whom he portrayed frontally. One can even see how some men's noses, like Froctrant's, had been bent askance. In these cases, the frontal pose seems to have commanded greater detail. It would say a lot about the ethics of gazing on a patient in order to take his portrait if looking him in the eye commanded Thomson to take a fuller, more individualising portrait. These features seem to be included as the residual signs of individuality, even though the primary function of the portraits is merely to show the passage of a weapon across the face.[758] We know that the bodily encounter between artist and sitter can affect artistic representations of the face.[759] This could well be a clinical medical example of this process at work.[760]

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[755] The exceptions are one anonymous bald soldier and the two soldiers whose portraits were taken from the waist position, where hair would not be, and indeed was not, so prominent.

[756] *Sketches*, ff. 50, 44.

[757] *Sketches*, f. 37.

[758] With this, cf. Crow, *Intelligence of Art*, 70.

[759] Cf. Rosenthal, 'She's got the look!'; J. M. Caldwell, 'The Strange Death of the Animated Cadaver: Changing Conventions in Nineteenth-century British Anatomical Illustration', *Literature and Medicine*, 25, 2 (2006), 325-357, at 351.

[760] It would not be the only military example, either: looking at a mutilated face caused Boitard to heroise Thomas Brown, a campaigner at Dettingen in 1743 and represent "the hero with his face mutilated in almost every direction." See Caulfield, *Remarkable Persons*, iii, 81.

The second nuanced type is those portraits that contain prognostic information. Earlier, we read about Alexander Kirkland's mouth-less portrait. Yet the portrait of an anonymous soldier who suffered exactly the same wound – and whose annotations are no more detailed than Kirkland's – *does* depict the full features of his profile. The annotations read "doing well". James Young "was doing well till continued fever supervened & he is now in danger". His portrait depicted (only) a single facial feature (Figure 110).[761] It is tempting to suggest that Thomson drew a fuller portrait when the patient was no longer in a critical condition. If this holds, it would suggest that Thomson was not quite as impervious to disfigurement and trauma (and perhaps grief) as might be thought, but was moved by the condition of his patient and adapted his art accordingly. I do not wish to argue that clinical accuracy was sacrificed to these impulses, but only to suggest that Thomson was perhaps not as unflinching (literally) in the face of bodily transformation. This is to say that showing the ill patient, and therefore presenting the patient's look, was indeed affected by how the artist-doctor looked on him. As such, portraits record Thomson's engagement in the psycho-ethics of patient portrayal within medical transactions.

All text and no image: the final report

The manuscript *Report* was penned in late July 1815 – at the end of the tour of the hospitals. A printed version followed in 1816.[762] Thomson delivered his verdict on the hospitals, which was mainly positive.[763] He compared British and French surgical methods.[764] And he proceeded to describe the various medical phenomena he had come across, including many cases. However, he did not see fit to include his portraits. Though

[761] *Sketches*, f. 24.
[762] For some initial comments, see Kaufman, *Surgeons at War*, 40, n. 76; and in the context of the 'national' body, Youngquist, *Monstrosities*, 175-6.
[763] E.g., *Report*, 23.
[764] E.g. *Report*, 26-7.

portraits may have told him all he needed to know about the wounded soldiers' cases, he did not see fit to transmit these visual records. Images were used to generate a textual report, but they did not accompany it.

A few things follow from this. First, it is entirely possible that the practicalities of publication did not warrant the expense or simply the bother of having the portraits 'made up' (cf. chap. IV).[765] Second, it is possible that Thomson thought of his portraits as working 'notes' that he understood but that required verbal elaboration for others. Third, it is possible that the portraits were products of a specific gestural knowledge – a medic's eye and artistic hand – that would not make sense to readers of the report, who included politicians. Whatever the most plausible answer, the disparity between the reliance on portraiture in the investigative phase of Thomson and Somerville's expedition and the complete absence of portraiture in the reporting phase only serves to reinforce the point that portraits were clinical documents that were flexible enough to meet the demands of recording what doctors saw, and what they needed to show, in 'real time'.

Interim conclusions

The experience of Thomson and Somerville in the Belgian hospitals and the evidence of their patient portraits indicate a number of things. First, doctors were comfortable in using annotated portraits as their primary and indeed unique point of reference for a case. Second, portraits could be helpful in circumstances where time and space were at a premium, when doctors moved around and when they observed lots of patients in quick succession. Unlike case notes, which could run to many bulky tomes (witness Hunter's, for instance) portraits can be said to have been a concise and efficient mode of documenting illness, which could be easily supplemented by written notes. Third, choices of pose, detail and expression all followed the demands of the cases at hand. Artistic skills were harnessed

[765]See below, chapter IV.

to medical exigencies, and portraits gained in detail as cases developed in complexity. Fourth, we have seen that, barring a couple of exceptions, Thomson and Somerville looked on their patients with an unimpassioned eye. In most cases, his patients' faces were partly-filled canvases that awaited the inscription of a wound. The accurate locating and recording of the wound took precedence over inscribing emotion or the patients' subjective response to their suffering. Finally, we saw that images were crucial to the gathering of medical data, but not to its presentation. This only serves to reinforce the argument that their primary function was as a clinical record. Overall, if his patient portraits suggest certain characteristics of Thomson's way of doing military medicine, then they are *about* him as much as the wounded servicemen. They allow us to interrogate the history of the patients *and* the doctors at the same time.

Conclusions

This chapter has sought to demonstrate how doctors looked on their patients' illnesses and used portraits to record what they saw. Each case-study doctor used portraits for many different reasons. However, each one is analytically similar insofar as their portraits of patients a) inscribed and embodied modes of medical looking and b) showed illnesses. Sometimes the portraits evince that the patient's disease was the focus of these looking and showing processes. In other circumstances, the portraits reveal that the patient himself was the focus. Moreover, this chapter has demonstrated that these processes of looking and showing combined in all sorts of medical practices and in all aspects of those practices. Different clues in the portraits themselves – from their formal mechanical properties to the way they were annotated and presented – reveal this variety.[766] If this chapter has shown

[766] To borrow Natasha Ruiz-Gomez's recent terms, the artistic properties reveal the indexical properties of patient portraits; N. Ruiz-Gomez, 'The 'scientific artworks' of Doctor Paul Richer', *Journal of Medical Humanities*, 39 (2013), 5.

that patient portraits were a fundamental part of early-modern doctors' medical life, then it has also shown how they are rich evidence of it, too.

On the point of evidence, the chapter has demonstrated how portraits' evidential status is not fixed. Portraits disclose doctors' practices, patients' statuses and medical knowledge. But rather than simply reflecting these things, portraits helped to constitute them. Portraits' meaning emerged in their part-reflective, part-constitutive medical capabilities. Indeed, we have seen how meaning emerged from different uses and how these uses were often about both recording and more actively demonstrating medical practice, patients' status and medical knowledge. Recognising how portraits' meaning can emerge from different circumstances and functions prepares the way for the following chapter's discussion of how they actively create and sustain medical relationships.

Also as far as evidence is concerned, the three case-studies of this chapter have shown how historians need not be so reliant on written sources. Anyone who insists, for instance, on the primacy of written sources in recovering the social history of clinical medicine should bear these case-studies well in mind. Written material is undeniably more plentiful. But as we have seen, text was not automatically prioritised by contemporaries. It was not at all relied upon to do certain things in certain circumstances. Images were often preferred to it. So text's analytically utility – for us as historians – should not be presumed obvious or sufficient. Indeed, on the basis of this chapter's findings, I would venture that historians would do most justice to work on the social history of doctors (and medicine broadly speaking) if they probed the mutual relationships and interdependencies between images and texts.[767] This sort of analysis is applicable not only to 'canonical' doctors with large archives, such as Cooper and Hunter, but to all manner of practitioners and all different forms of text and image.

[767] Cf. the note by Alexander Wragge-Morley on the Royal Society's Curiously Drawn conference: http://picturingscience.wordpress.com/2012/06/28/some-thoughts-on-curiously-drawn-the-origins-of-science-as-a-visual-pursuit/; accessed 5th March, 2013.

Having mentioned that Hunter and Cooper (in particular) are firmly in the canon of important long eighteenth-century doctors, we must ask about the representativeness of this chapter's three case-studies. Not all doctors will have produced as many portraits as Hunter and Cooper. Not every doctor built up such a sizeable collection of preparations as Hunter did. Not every doctor was assigned field-work on the battlefield. Are not portraits rich evidence only of those doctors who made lots of portraits? I would suggest that what sets Hunter, Cooper and Thomson and Somerville apart is simply the quantity of extant portraits, not the significance that was imputed to them. Even doctors who produced fewer patient portraits took great care to make them detailed, accurate and easily analysable – a point that the next chapter shall pursue. Moreover, there are examples beyond the 'canon'. A less-known provincial series of evidence might be the art produced by the Leeds Medical School. The school employed artists (among other things) "to assist in...making anatomical preparations and other illustrations of lectures".[768] It is probable, if not conclusive, that some of the watercolour paintings in the series of gentlefolk of Leeds depicted with their illnesses were made by such artists; they would certainly repay closer scrutiny along the lines of this chapter.[769] But all in all, that three very different doctors, with very different interests, formations and expertise, should have had made portraits of their patients to fulfil a wide range of clinical and analytical aims suggests powerfully that portraits were a core part of long eighteenth-century doctors' work. Any further investigation into the place of portraits in other doctors' practices would doubtless reinforce this central point, and add colour to what at the moment can be but a lightly sketched picture.

[768] S. T. Anning and W. K. Wallis, *A History of the Leeds School of Medicine: One and a Half Centuries 1831-1981* (Leeds, 1982), 11, 21.

[769] This series is in WL. I am grateful to Dr William Schupbach for his assistance with these portraits.

Chapter IV – Portraits and medical relationships

Introduction

In the last chapter, we examined doctors' portraits of their patients. Doing so helped us query just how early-modern medics – and medicine itself – actually worked. It emerged that patient portraits could fulfil doctors' need to understand diseases *and* patients. As well as illustrating clinical information and being devices for clinical analysis, patient portraits also evinced the specific medical relationships that obtained between patients and different early-modern medical practitioners (including artistic assistants). This point begs a question equally fundamental to early-modern medicine: how were early-modern medical relationships actually formed and conducted, and what was the role of portraiture?

This chapter answer this question in two ways. The first way, which forms the first part of the chapter, is to consider the use of patient portraits as a special and distinct kind of illustration in books and adverts. This basically probes how patient portraits helped to construct and manage relationships of shared knowledge and occupational status by carrying medical information in publications. Some key questions drive this enquiry. They emanate from a broad historiography on the use of images in the production of knowledge. They also ally patient portraits to a burgeoning literature on medical illustration and medical publishing. How and why were patient portraits used when knowledge was to be disseminated? What decisions and techniques went into making them and why? What were they preferred to? What did they give to books, adverts or doctors' reputations that might not have been achievable by other means (such as other illustrations)? Were there any barriers to using patient portraits – consent, for instance – and what effect did these have on the knowledge conveyed?

The answers to such questions lead to the following arguments. First, patient portraits were an efficient and prestigious way of conveying knowledge, i.e. of bringing

relationships of knowledge into being. Second, they were carefully considered artistic products that often underwent significant alteration between preparatory phases and final publication. Authors cared about conceiving and making good quality portraiture – i.e. using artistic and visual skills – since doing so betokened their trustworthiness and expertise. Third, authors used their patient portrait illustrations to inculcate certain habits of seeing and perceiving among their peers. These were equally crucial to their collective identification as medical experts. In other words, authors used patient portraits to build and fortify relationships between their peers that were based on a combination of medical knowledge and visual intelligence.

The second way of answering the main question, which forms the second part of the chapter, also builds on the last chapter's insight into how portraits evince medial relationships. Instead of looking at immediate clinical relationships, however, I shall consider the wider social qualities of patient portraits. I shall consider how portraits mediated the common or mutual medical interests that people had in each other's lives. Those interests – or we might call them affinities – encompass what I define as a 'medical relationship'. Such interests or affinities were diverse. They included, *inter alia*, cultural interests among medical 'virtuosi' and emotional affinities developed between patients and their caregivers. The second part hangs on a few key sub-questions. How did portraits contribute to creating, cementing and commemorating what was medical about a relationship? What were portraits thought to be able to *do* for people? Precisely what about portraits bound people's medical experiences? How did portraits construct and mediate the links between people's medical lives?

Working through these questions compels a number of arguments. The first is that the mere existence of a portrait transaction – whether in commissioning, making, purchasing, receiving, looking at a portrait, etc. – could signal a medical affinity between the transaction's participants. In fact, the resulting portrait and its 'afterlife' could encapsulate people's mutual medical interests (cf. Introduction). For instance, a portrait of

a patient commissioned by a doctor signalled a wider cultural kinship of which the medical relationship was just a part. Meanwhile, the practice of swapping portraits could bring emotional comfort to ill sitters. The second argument is that portraits, by their look and feel, were tailored to suit the particular relationship that inspired them. Once again, like the portraits of the preceding chapters, the portraits of this chapter embodied specific artistic choices and were borne of locally contingent circumstances.

Like the first three chapters, this chapter considers general material before examining some case-studies in more detail. In the first section, it has been impossible to be too selective. The two case-studies – Sir Alexander Morison and Francis Sibson – are very much from the tip of the tail end of the long eighteenth century. This chronological leaning owes as much to the hazards of source survival as to any (putative) change in the significance of patient portraits. It owes particularly to the survival of preparatory sources, which the above questions command us to consider. (Of course, during our period as a whole, source survival and source significance were often very closely related: William Cheselden purposefully destroyed the working drawings, copperplates and a number of unsold printed copies of his celebrated *Osteographia* (1733) precisely in order to keep the work rare, costly and prestigious.)[770] The second section also proceeds from general examples of different types of medical relationship to a more detailed examination of the medical relationships of Alexander Pope, he of chapter II.

Again like the previous chapters, this chapter's principal methodology is to pay close attention to the portraits themselves – to analyse common patterns and visual devices and to juxtapose them with any companion text. (This last method is especially crucial when considering illustrated books.) Paying such close attention helps us consider how art can constitute relationships and evoke affinity between the different historical agents whose will and efforts brought portraits into being. In the first half, teasing out

[770] Cheselden, *Anatomy of the Human Body*, Advertisement; cf. M. Kemp, '"The mark of truth": looking and learning in some anatomical illustrations from the Renaissance and the eighteenth century', in Bynum and Porter (eds.), *Medicine and the five senses*, 85-121, at 104.

portraiture's relationship-constructing abilities requires us to pay attention to the different phases of the publication process. In particular, I ponder how art may have been adapted for publication. As Bruno Latour has forcefully argued, final published images may be a 'mobilised' end-version of what they betoken.[771] In many instances, doctors instructed artists and printers to make alterations. Doctors envisioned in precise terms what they wanted their readers to see and comprehend. Doctors also commented – especially in prefaces – about the 'road' to the final proof. I argue these textual 'penumbras' spelled out doctors' mastery of the visual skills activated in making and publishing portraits.[772]

In the second half of the chapter, much rests on the reconstruction of patients' networks of acquaintance and friendship, as well as more obvious relationships with medics. The analytical purchase of the concept of the 'network' has greatly increased in recent generations. Besides the history of medicine, it has been applied to the histories of politics,[773] economics,[774] geography and globalization,[775] nationalism;[776] religion[777] and science[778]. More often than not, it offers a way of understanding the significance of the movement of ideas, influences, people and goods. The concept accords great – even causal – significance to the precise qualities of social interactions and the cultural webs that historical actors weave. As the Introduction showed, friendships and all manner of socio-cultural experiences bore on people's medical lives. Since one common rationale for

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771 B. Latour, 'Visualisation and Cognition: Drawing things together', *Knowledge and Society*, 6 (1986), 1-40, esp. 7ff. Roberta McGrath, for instance, has described anatomical atlases (and their plates) as mobilised inscriptions of female flesh: R. McGrath, *Seeing her Sex; Medical Archives and the Female Body* (Manchester and New York, 2002), esp. 10-12.

772 See Jordanova, *Look of the Past*, 195ff.

773 E.g. L. B. Namier, *The Structure of Politics at the Accession of George III* (London, 2nd ed., 1963).

774 E.g., N. Glaisyer, 'Networking: trade and exchange in the eighteenth-century British empire', *Historical Journal*, 47, 2 (2004), 451-76.; C. Muldrew, *The Economy of Obligation: The Culture of Credit and Social Relations in Early Modern England* (Basingstoke, 1998).

775 Especially A. Appadurai (ed.), *Globalization* (Durham, NC and London, 2001);

776 B. Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (New York and London, 2nd ed., 2006).

777 E.g. B. J. Kaplan, *Divided by Faith: Religious Conflict and the Practice of Toleration in Early Modern Europe* (Cambridge, MA and London, 2007).

778 Especially sociologically-informed conceptions of science, such as Latour's actor-network theory.

making portraits was to mark these experiences, reconstructing portrait networks is a very useful way of studying medical relationships.

Publishing patient portraits

As explained above, the first part of the chapter interrogates the use of patient portraiture in books, or publications generally speaking. (By publications, I mean any source that was intended to make something generally known by setting it forth in a specifically conceived medium.) I chart how patient portraits fit into the histories of publishing and medico-scientific illustration. I then turn attention to the specific challenges involved in making patient portraiture and the benefits that using such portraiture conferred (to repeat, as a special kind of illustration).

Medical publication, advertisement and illustration

The long eighteenth century was a fast-paced age in the history of publishing. General literacy rose. More items were produced and consumed than ever before. People even wrote and painted about reading. There was a medley of different media and different kinds of author. The issues of copyright and censorship were vexed and seldom resolved without dispute. The pamphlet, the heir to the seventeenth-century broadsheet, was a particularly powerful weapon in wars of words – not least among medics.[779] Medical publication and advertising were multimedia industries subject to the vicissitudes of broader trends in publishing. The ubiquity of advertisements for patent medicines, for instance, was inextricably bound up with the proliferation of news-sheets and journals.[780]

[779] See e.g., D. N. Harley, 'Honour and Property: The Structure of Professional Disputes in Eighteenth-Century English Medicine' in A. Cunningham and R. French, (eds.), *The Medical Enlightenment of the Eighteenth Century,* (Cambridge, 1990), 138-164.
[780]E. L. Furdell, *Publishing and Medicine in Early Modern England* (Woodbridge, 2002), 137 (and ch. 7).

Meanwhile, the popularity of bedside medical self-help companions owed much to the growth in general literacy and the availability of cheap editions.[781]

Even within specifically medical publishing, trends were not constant. Late seventeenth- and early eighteenth-century academic medicine was a bookish enterprise.[782] Sometimes composed in Latin, text-books were decidedly by the medical faculty – Oxbridge, Scotland or the continent – and decidedly for the medical faculty; often they were dedicated to a tutor or fellow practitioner. Perhaps paradoxically, though, these books were not just niche tomes written to gather dust ostentatiously in a medical library, but rather penned with an eye for profit. Richard Mead advised that "should you have an itching to make your name by a book, [you should] choose one that will be business and money-making".[783]

Mead's comment implies a wider (buying) readership than the faculty alone. As the Introduction noted, the gap between professional and lay medical knowledge was not all that great, especially among the more genteel. And publications like the *Gentleman's Magazine* kept the cultivated amateur reader abreast of the latest developments and medical advice.[784] Herbals, almanacs and the like were ever-present on the cheaper bookstands. We have already noted that self-help manuals like Buchan's were second in breadth of readership only to the Bible.[785] Mead also implied that doctors should target fashionable medical issues. Gout was particularly lucrative in this respect.[786]

As our period elapsed, learned medical societies' transactions, as well as specialised and openly commercial journals, appeared more and more. In an age that appreciated the cumulative acquisition of knowledge by discrete investigation and casuistry, such series

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781 Lane, "'The doctor scolds me'".
782 Lindemann, *Medicine and Society*, 96.
783 Cit. R. French, *Medicine before Science: The Business of Medicine from the Middle Ages to the Enlightenment* (Cambridge, 2003), 199.
784 Porter, 'Laymen, doctors and medical knowledge'.
785 L. H. Curth, Medical Advertising and the Popular Press: Almanacs and the Growth of Proprietary Medicine', in *eadem* (ed.), *From physick to pharmacology: Five hundred years of drug retailing* (Aldershot, 2006), 29-47.
786 See R. Porter and G. S. Rousseau, *Gout: A Patrician Malady* (New Haven and London, 1988), ch. 5-8.

were, by the final quarter of the eighteenth century and beyond, no less favoured than monographs.[787] Indeed, their numbers multiplied as public interest in 'theoretical' medicine increased. (Public lectures were often published, too.) The beginning of the nineteenth century saw a "rash" of new periodicals. Among them was the still-published *Lancet* – a journal which, as mentioned earlier, was literary and medical and which targeted lay readers as much as medical practitioners.[788]

Mead's comment anticipated what historians have since noticed about early-modern medical publications. As well to impart information, they were a means of self-advertisement for their authors. Books were designed to assert their authors' mastery of a subject.[789] Susan Lawrence has also noted that case reports – including the mentioning of patients' names – stood as matters of fact and "emphasized the unassailability of direct experience".[790] Publications also appealed to their readerships by matching readers' intellectual expectations. Meegan Kennedy has argued that case reports took literary forms most likely to match readers' expectations of written form, tone and detail.[791] All in all, accurately recording a first-hand medical transaction in an intellectually appropriate manner conferred on authors both trustworthiness and authority.

Portraiture helped in this endeavour, too. As David Alexander has argued, medical authors and purveyors of medicine like William Salmon and Lionel Lockye(a)r were confident that "the public wanted to see their honest faces". This prompted them to include 'frontispiece' style portraits alongside their adverts and books.[792] This begs a

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[787] See U. Tröhler, *To Improve the Evidence of Medicine: The eighteenth-century British Origins of a Critical Approach,* (Edinburgh, 2000), 11; J. R. Topham, 'Scientific and Medical Books 1780-1830', in M. F. Suarez and M. L. Turner (eds.), *The Cambridge History of the Book in Britain. Volume 5 1695-1830* (Cambridge, 2009), 827-33, at 828-9.

[788] Topham, 'Scientific and Medical Books', 830.

[789] Lawrence, *Charitable Knowledge*, 314.

[790] Lawrence, *Charitable Knowledge*, 239.

[791] M. Kennedy, 'The Ghost in the Clinic; Gothic Medicine and Curious Fiction in Samuel Warren's Diary of a Late Physician', *Victorian Literature and Culture*, 32, 2 (2004), 327-51, esp. 241. The Sydenham Society would later formalise such guidelines; I am grateful to Brian Hurwitz for this point.

[792] D. Alexander, 'Faithorne, Loggan, Vandrebanc and White: The Engraved Portrait in Late Seventeenth-century Britain', in M. Hunter (ed.), *Printed Images in Early Modern Britain: Essays in Interpretation* (Farnham and Burlington, 2010), 297-316, at 299.

question that our material will consider: what was the role of patients' faces in these publications?

Medical illustration

If their own portraits assisted doctors' publicity efforts and lent authority to what they wrote, then so did illustrations generally. (At this point in the discussion, I refer to illustrations generally, not portrait illustrations specifically.) Although not all medics avowed the usefulness of illustrations,[793] Stephen Benson has convincingly argued that good-quality illustrations tended to improve the chances of a book's success – at least among the scholarly classes.[794] Books were advertised as "illustrated" even if they contained very few illustrations. Even if it only justified the tagline, it paid to include at least one illustration.[795] Like publications broadly speaking, illustrations were tailored to their social and intellectual *milieux*, a point fleshed out below.[796]

The main obvious selling point of illustrations was that they supplemented and/or excelled the information contained in words, specimens and preparations. As Alexander Watson said of eye diseases, "they cannot well be understood by verbal descriptions alone".[797]Illustrations also afforded greater analytical purchase. As Robert Hooper wrote of his engravings of types of brain disease, they would be "in some respects more useful than the preparations themselves ... [in that] they enable the pathologist to distinguish organic diseases...and thereby to dispose them into classes".[798] And Robert Willis thought – just like

[793] George Alley thought plates "appeared...to confuse more than assist the verbal description" of his *Essay on a peculiar eruptive disease* (Dublin and London, 1803), Advertisement.
[794] Benson, 'Left out of the Story?', 6.
[795] Examples of this include H. C. Stephens, *A treatise on obstructed and inflamed Hernia: and on Mechanical observations of the Bowels internally* (London, 1831) or Alexander Monro (III)'s *Morbid Anatomy of the Brain* (Edinburgh, 1827).
[796] Kemp, 'Mark of Truth', 103.
[797] A. Watson, *Compendium of diseases of the human eye* (Edinburgh and London, 3rd ed., 1830), viii; cf. C. J. B. Williams, *A rational exposition of the physical signs of the diseases of the lungs and pleura* (London, 1828), xii.
[798] R. Hooper, *The Morbid Anatomy of the Human Brain: Being Illustrations of the Most Frequent and Important Organic Diseases to which that Viscus is Subject* (London, 1826), Advertisement.

his inspiration Thomas Willan – that his *Illustrations of Cutaneous Diseases* (1841) would constitute a "Compendious Practical Guide to a Knowledge of their intimate Nature".[799] That is, they would serve for doctors as building blocks of medical knowledge and as rubrics for medical analysis.

In this vein, the now vast historiography of ('scientific' and) medical illustration centres on how images were invested with knowledge-bearing and knowledge-transmitting capabilities.[800] Over the course of our period and beyond, medics used painstaking methods and techniques in the quest for reproducible exactitude and what might be called the illusion of the absence of mediation. Referring to the eighteenth and late twentieth centuries respectively, Simon Chaplin and Kelly Joyce have shown how renditions of body fragments and MRI imaging became equated with bodies *tout court* and so were taken as expertly made, reliable visual artefacts.[801]

Lorraine Daston and Peter Galison have argued that the later nineteenth-century witnessed a shift in the notion of objectivity. Gone was the idealism of the eighteenth century, which held that investigators' own senses and actions would not affect the reliability of their 'true-to-nature' data (including pictorial representations). Instead, 'mechanical objectivity' held that machines and instruments could supply the standardisation that human judgments, hands and eyes could not. Daston and Galison also argue that the switch in favour of mechanical objectivity was fuelled by a *moral* imperative: experimenters and recorders should exercise an almost monastic self-restraint not to

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[799] R. Willis, *Illustrations of Cutaneous Diseases: A series of Delineations of Affections of the Skin in their more interesting and frequent forms* (London, Paris and Leipzig, 1841), Preface; cf. T. Bateman, *Delineations of Cutaneous Diseases* (London, 1817), viii and R. Bright, *Reports of Medical Cases* (London, 1827), vii.

[800] P. H. Smith and B. Schmidt, *Making Knowledge in early modern Europe: Practices, Objects, and Texts, 1400-1800* (Chicago and London, 2007); S. Kusukawa and I. Maclean (eds.), *Transmitting Knowledge: words, images and instruments in early modern Europe* (Oxford, 2006); Latour, 'Visualisation and Cognition'. S. Kusukawa, *Picturing the Book of Nature: Image, Text, and Argument in Sixteenth-Century Human Anatomy and Medical Botany* (Chicago and London, 2012), esp. ch.5ff.

[801] Chaplin, 'John Hunter and the Museum Oeconomy', 124; cf. Alberti, *Morbid Curiosities* and K. Joyce, 'Appealing Images: Magnetic Resonance Imaging and the Production on Authoritative Knowledge', *Social Studies of Science*, 35, 3 (2005), 437-62.

interpose their subjectivity between nature and the machine that would – *could* – document nature objectively.[802]

Despite their rigid periodization, many of the technological characteristics of 'mechanical objectivity' noted by Daston and Galison are noticeable in the illustrations of our period. Although they were not accompanied by a similar moral drive as the later nineteenth century, many technologies and mechanisms bear witness to the broad long eighteenth-century effort not to taint illustrations with subjectivity. Indeed, William Cheselden's *camera obscura*, Bernhard Albinus' 'grid of strings', standardised colours, colour mezzotinting, (hard-wearing) lithographs, (uniform and comparable) schematic diagrams and the widening of the "*ad vivum*" and "from nature" banners – all were but a few ways of trying to collapse the gap between representations themselves and what they represented.[803] Charles Jenty captured the spirit of some of these trends. He preferred the mezzotint to the line engraving because "it is softer...[and] Nature may admit of light and shade, well blended and softened, but never did of a harsh outline"; while he came to adopt colour illustrations precisely because they were "as nearly as possible imitative of Nature".[804] If "let nature stand for itself" was a catchphrase of later nineteenth-century scientific illustration, then it was a mantra familiar to our period, too.

Despite the aesthetically complex nature of many of these technologies, the impulse to represent nature as accurately and truly as possible required artistic 'ornaments' to be suppressed. Kärin Nickelsen has shown how certain German botanists preferred

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[802] Daston and Galison, 'Image of Objectivity', esp. 82-103; *iidem*, *Objectivity* (Cambridge, MS, 2007), esp. ch. 2. Schaffer, 'Astronomers Mark Time'.

[803] M. Kemp and M. Wallace, *Spectacular Bodies: the Art and Science of the Human Body from Leonardo to Now* (London, 2000), 41; K. Nickelsen, 'The challenge of colour: Eighteenth-century botanists and the hand-colouring of illustrations', *Annals of Science*, 63, (2006), 1-23, esp. 10-12; Stafford, *Body Criticism*, 75, 42; Kusakawa, S. Kusukawa, 'Picturing Knowledge in the early Royal Society: the examples of Richard Waller and Henry Hunt', *Notes and Records of the Royal Society*, http://rsnr.royalsocietypublishing.org/content/early/2011/05/10/rsnr.2010.0094.full.pdf+html, accessed 2 July, 2012, 8 (esp. the work of C. Swan, which she cites).

[804] C. Jenty, *On the demonstration of a pregnant uterus* (London, 1757), Note to the Reader; *idem*., *On the demonstration of the human structure, half as large as nature, in four tables* (London, 1757), 6.

illustrations drawn in a "flat, exact manner" to those done in a "bold Painterly-like way".[805] In a similar vein, James Caldwell has argued that in early nineteenth-century Britain, where the depiction of faces was necessary in an illustration, all emotion was effaced because depicting emotion depended too much on the imagination of the artist. An illustration that strayed too close to expressive portraiture interfered with and diluted its claims to show self-evident truths (although cf. below).[806]

Indeed, the 'interlocutory' or intermediate role of artists in the production of medical illustrations was a source of enormous anxiety for early-modern medical authors. As I shall set out in more detail for patient portraits, authors kept an eagle eye on their illustrators.[807] Besides supervising them, authors tried to make sure that their artists knew about what they were drawing.[808] The artist's role captured particularly well the tension of using potentially ornamental techniques to fulfil un-ornamental aesthetic expectations.

Authors accordingly tried to manoeuvre their readers away from focussing on the artist's representation towards concentrating on theirs and their readers' own ability to observe the representation. As the naturalist Alexander Pitfield commented, it was better for drawings not be done by trained artists because "the Importance is not so much to represent well what is seen, as to see well what should be represented".[809] This mantra applied to medicine, too. French dermatologist J.-L.-M. d'Alibert wanted his illustrations "to instruct...the sight through seeing."[810] William Hunter summed up the beneficial combination of good illustrations and knowledgeable seeing as follows:

> The art of engraving supplies us with...an universal language. Nay, it conveys clearer ideas of most natural objects than words can express; makes stronger impressions upon the

[805] K. Nickelsen, 'Draughtsmen, botanists and nature: constructing eighteenth-century botanical illustrations', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 37 (2006), 1-25, at 19.
[806] Caldwell, 'Animated Cadaver', esp. 348-9.
[807] For a starting point, see Kemp, 'Mark of Truth', 107.
[808] Nickelsen, 'Draughtsmen, botanists and nature', 7-11.
[809] Cit. Kusukawa, 'Picturing Knowledge', 7.
[810] Chaplin, 'John Hunter and the Museum Oeconomy', 124, 132; Stafford, *Body Criticism*, 303.

> mind; and to every person conversant with the subject, gives an immediate comprehension of what it represents.[811]

Medical knowledge acquired via illustrations, then, was the sum of artists' representational skills and practitioners' observational skills. Yet only the latter could realise the full potential of engraving. The "disciplinary eye" of the doctor – i.e. a particularly 'gesturally knowledgeable' period eye – would render different images intelligible inscriptions of medical knowledge.[812] Doctors sought to minimise the importance of the artistic production side of the equation as much as they could – i.e. they tried to emphasise their own visual skills. (However, as we shall see, one way in which their fellow medics deployed the visual skills that medical authors promoted was in critiquing the quality of their illustrations.)

For all the tension between the aesthetic and technical qualities of illustration, and for all that doctors sought to minimise artists' 'footprints', author-artist collaborations were not one-sided. They could be genuinely collaborative and even harmonious.[813] Richard Mead borrowed (his patient) Jean-Antoine Watteau's *commedia dell'arte* figures in his public dispute with John Woodward.[814] William Sharp was trusted to engrave John Hunter's portrait by Reynolds just as he was to make the plates for Hunter's work on venereal disease. Artists worked hard to win medico-scientific commissions. Patronage was milked from connections near and far.[815] Artists cared about their own reputations for quality. Matthew Baillie recognised this when he wrote of William Hunter's *Gravid Uterus* that "the five artists were employed, who, while they contributed to the Improvement of a most interesting part of science, were ambitious at the same time of adding to their own

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811 Hunter, *Gravid Uterus*, preface.

812 Cf. Daston and Galison, *Objectivity*, 48.

813 The work on Charles Darwin's concern for his illustrations is one example: J. Smith, *Charles Darwin and Victorian Visual Culture* (Cambridge, 2006), 9, 28, 33 – and, generally, D. Donald and J. Munro (eds.), *Endless Forms: Charles Darwin, Natural Science and the Visual Arts* (New Haven, 2009).

814 C. A. Hanson, 'Dr Richard Mead and Watteau's "Comediens italiens"', *Burlington Magazine*, 145, 1201 (2003), 265-72.

815 E.g. Benson, 'Left out of the Story?'.

reputation."[816] Indeed, if artists ever knowingly conformed to an author's 'house' style – as Carin Berkowitz has recently argued – it might have owed as much to artists' cooperation and desire to be flexible (and be recognised as such) as it did to authors' success in dictating their output.[817] Besides, as we shall see, authors did genuinely value artists' expertise as well as their access to high-quality suppliers of materials (e.g. paper).[818] Moreover, unless like the Bell brothers authors could rely on their own draughtsmanship, they relied heavily on artists' skills.[819]

Published patient portraiture

Such is the background to the first part of the chapter. Medical illustrations were meticulously planned productions that helped, in their own way, to transmit knowledge and advance reputations – particularly by promoting the ability to see and scrutinise in a certain way. Being collaborations among their conceivers and makers, such illustrations had to balance different knowledge and skill levels, different motives and interests and different understandings of form and style. Because patient portraits were recognised as conceptually complex illustrations that posed particular challenges to conceiver-maker (doctor-artist) teams, and because they were thought to carry specific advantages over 'general' illustrations, examining them helps us move forward from this background and better our understanding of the medical relationships that publication sought to solidify.

Whilst published patient portraits (like patient portraits generally) constitute a gap in the long eighteenth century history of medicine, historians of other periods have recognised some of the advantages that they bestowed on publications. Some of these

816 W. Baillie, *An anatomical description of the human gravid uterus* (London, 1794), viii.
817 C. Berkowitz, 'Knowledge Claims, Authorship and Aesthetics in the Anatomical Atlases of Enlightenment', paper delivered to AAHM conference, Baltimore, 27th April, 2012.
818 Berkowitz, 'Knowledge Claims'.
819 T. J. Connolly and S. H. Clark, 'Introduction', in *iidem*, (eds.), *Liberating Medicine 1720-1835* (London, 2009), 1-10, at 5; Benson, 'Left out of the Story?'.

anticipate our findings. Philipp Osten has shown how photographs of disabled children at the Oskar-Helene Home were adapted for various publicity drives, including trying to secure state finance and private patronage, and to promote the social and medical promise of "modern cripple care".[820] Lam Qua's portraits of patients were exhibited in many cities by the missionary Peter Parker as he travelled between China and the West trying to gather funds for missionary hospitals.[821] Many of these reputational and commercial impulses have an earlier visual history than might be imagined.

A special kind of illustration: the unique properties and implications of portraits

Publishing patient portraits presented a number of unique challenges and gave rise to a number of specific characteristics and interventions by doctors. One obvious matter, as William Cheselden recognised in 1713, was to depict a living person.[822] This had immediate implications for the representation of personality and individuating features (like clothes). As noted above, Caldwell has argued that medical artists consciously sought to suppress these features for illustration. However, as we shall see in Alexander Morison's case, certain disciplines were founded directly on the relation between living expression and personality.

The second and third entangled problems were those of time and the fragmented body.[823] The fact that patients' bodies were – more often than not – whole when they presented to doctors posed the question of how much of the body should be represented. We saw this question dealt with in the 'operational portraits' of the last chapter, which sometimes chose to focus only on a single body part and sometimes on more complete bodies. Similar questions were posed when portraying patients post-mortem. Dissection

[820] P. Osten, 'Photographing Disabled Children in Imperial and Weimar Germany', *Cultural and Social History*, 7, 4 (2010), 511-32.
[821] Heinrich, *The afterlife of images*; Gilman, 'Lam Qua and the development of westernized medical iconography in China'.
[822] Furdell, *Publishing and medicine*, 167.
[823] Alberti, *Morbid Curiosities*, ch. 5-6.

allowed body fragments to be isolated. But dissection was an example of human mediation, and it took time to execute. In order to try to minimise the epistemological and time gaps between the natural body and the parts that needed to be drawn, doctors responded in a number of ways. Some sought to dissect and have drawn their patients as quickly as possible. John Lizars was especially keen to advise his readers that the drawing he made of "Janet I—" in his treatise on ovarian disease was "represented immediately after the incisions ha[d] been made through the abdominal parietes".[824] Others tried to turn the problem into an advantage. Simon Chaplin has argued that detaching parts and reproducing them in obviously decontextualised settings – no background, no shadow, no recognition of the original wholeness of the body or where it had come from – was a way for John Hunter to assert the status of such images as the proper focus of (expert) scrutiny.[825]

A fourth (and general) problem was one of scale. Doctors worried about reducing large organs and body parts in smaller books. This was also turned to their advantage. Scaling down gave doctors the chance to state how closely they supervised their publication drawings. John Howship, for instance, took the chance to write that "the figures from which the plates have been engraved, are for the most part, on a reduced scale, but I have attended so closely to the engravings, as well as the drawings from which they were made [by Howship himself], that...they will not be found to suffer...in point of interest, or of accuracy..."[826]Not only did Howship put his name to all the plates, but he also annotated specific comments on scale.[827] Other doctors tried (literally) to face up to this problem. As we shall see, Francis Sibson made relational drawings that showed the part within the whole. Even though they focussed on individual parts, his drawings allowed readers to situate parts within the personalised body they came from.

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[824] J. Lizars, *Observations on the Extraction of Diseased Ovaria* (Edinburgh, 1825), 11-14.
[825] Chaplin, 'John Hunter and the Museum Oeconomy', 124.
[826] J. Howship, *Practical observations in surgery, and morbid anatomy* (London, 1816), vii.
[827] Howship, *Practical Observations in surgery*, pl. 3, figs. 1, 2; pl. 5, fig. 3; pl. 7.

The advantages of using patient portraits

As Howship's example indicates, doctors seized on opportunities to point out that they had closely grappled with preparatory production issues. Their open acknowledgement of them and their close involvement in dealing with them contributed to their self-publicity as careful, skilful and trustworthy purveyors of medical knowledge. Doctors also recognised that patient portraits – as opposed to other types of illustration – would bestow particular advantages on their works as well as themselves *qua* doctors.

For one thing, patient portraits helped when it came to arguing how diseases varied – by manifestation, look, consequence etc. – according to patients' individual and specific circumstances. (We saw in the previous chapter how important this was to doctors.) In this sense they were an extension of named cases.[828] For instance, William Cheselden's copperplates in *The Anatomy of the Human Body*, engraved by Sutton Nicholls, included individual patients with individual problems – such as Margaret White's prolapsed colostomy (Figure 111).[829] White's portrait allowed Cheselden to inform his readers that he found her "in this condition". The portrait showed all Cheselden needed to say about the condition as it manifested in her. Dermatologists Willan's and Bateman's *unidentified* portraits, by contrast, merely delineated the skin diseases their patients suffered from – even though the pair specifically chose patients with interesting idiosyncratic dermatological problems to sit for them. Not identifying their patients was a means conceptually to separate the diseases from the patients, thereby advancing their (patient-independent) classification scheme. Willan's and Bateman's portraits could have been of anyone – just as the diseases they classified could ail anyone. In other words, their

[828] For a German perspective on such issues, see K. Nolte, 'An age of medical paternalism? Reflections on medical disclosure and patient consent in nineteenth-century Germany', *Med. Ges. Gesch.*, 25 (2007), 59-89. Nolte argues that German medics were keen to stress the awareness of the need for patient disclosure in their published reports.

[829] Cheselden, *Anatomy of the Human Body*, 324f., tab. 40.

publication choices evince their prioritisation of diseases over patients.[830] Just as Hunter's and Cooper's clinical portraits revealed their ontologies of disease, so published patient portraits also promoted certain conceptions of (more or less individualised) disease.

It is worth diverting here momentarily to consider the issue of consent. For that influenced the matter of naming patients. Some authors reduced their patients to "cases", or "instances".[831] Others identified their patients – often with varying levels of explicitness.[832] Naming a patient seemed to have required his specific consent. As such, it implies a relationship of authority and power between author and patient. Malcolm Flemyng noted in his *Discourse on the nature, causes and cure of Corpulency,* that he "had not obtained leave to mention in print, the person's name upon whom the cure was made".[833] Edward Johnson would have sympathised generations later when he came to publish his *Hydropathy*, for he had "not, in every instance, been permitted to give the names of patients".[834] Edward Harrison, on the other hand, "made it a constant rule to refrain from the mention of names, when I had occasion to censure".[835] But that did not stop him from describing personally – or indeed from drawing – many of his patients in his *Pathological and practical observations on spinal diseases*. Authors felt their claims were less sure-footed without naming their patients. Both Flemyng and Johnson, debarred for some reason from supplying patients' names, sought to reassure their readers that readers *could* learn the identity of their patients, albeit privately. Johnson assured his readers that "they [his patients] have all allowed me, if any doubt arises as to the authenticity of their reported

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830 Bateman, *Delineations of Cutaneous Diseases*.

831 E.g. P. Pott, *A treatise on the hydrocele, or watry rupture, and other diseases of the testicle, its coats and vessels* (London, 1767); W. Baillie, *The Morbid Anatomy of some of the most important parts of the human body* (London, 1793); W. E. Farr, *A treatise on the nature of scrofula* (London, 1820).

832 See e.g. E. Jenner, *An inquiry into the causes and effects of the variolae vaccinae* (London, 1798); W. Taylor, *On a new and successful treatment for febrile and other diseases, through the medium of the cutaneous surface* (London, 1850); and John Heaviside, in Howship, *Practical Observations in surgery*, case 31.

833 M. Flemyng, *Discourse on the nature, causes and cure of Corpulency, illustrated by a remarkable case* (London, 1760), vii.

834 E. Johnson, *Hydropathy. The theory, principles, and practice of the water cure shewn to be in accordance with medical science and the teachings of common sense* (London, 1843), x.

835 E. Harrison, *Pathological and practical observations on spinal diseases illustrated with cases and engravings, also an inquiry into the origin and cure of distorted limbs* (London, 1827), xv.

cases, to give their names and addresses on personal application."[836] Flemyng even gave names of other doctors who would vouch for him.

Published portraits enabled doctors to be specific in other ways, too. In chapter III, we saw how doctors used portraits to communicate at a distance about their patients' cases. Medical publications were a public channel for this. Portraits stood alongside individual case-notes in public correspondences among the faculty. For instance, in the *London Medical Gazette* of October 3rd 1835, Alexander Shaw communicated a case history and a drawing of John Barnes for the simple reason that

> the case of injury of the spine related by Mr. Stafford to the Royal Medical and Chirurgical Society...resembles a case which occurred some years ago in the Middlesex Hospital, of which I have preserved the notes and a drawing. Perhaps these may be interesting to your readers.[837]

Periodicals and journals allowed doctors to recreate the initial inspection of a patient on the ward or in his patient room and/or the scene in the operating theatre.

Publishing patient portraits also meant that doctors could be specific about the nature of appearance at certain points in time (again, cf. chap. III). Noting exactly when a portrait was taken lent weight to discussion about the look of a disease at a certain point in its progress. A portrait taken a definite time elided the (necessary) time it took to make the portrait. This contributed to the effect of unmediated showing. A fixed-time portrait also stood as an image for all time. (All publications aim to stabilise and present information as timeless and accessible whenever they are read.) In his 1846 treatise on teeth, Joseph Fox included four portraits of Sarah Dulwich that charted the stages of a tumour on her admission, "two months later" and "a short time before her decease".[838] The portraits were

[836] Johnson, *Hydropathy*, x.
[837] *London Medical Gazette*, 17 (1835), 936-8.
[838] J. Fox, *The natural history and diseases, of the human teeth* (London, 1814), plate 10.

not copiously annotated, but were made just to give to readers an awareness of the look of diseases at certain points in its progress. The same premise underpinned the portraits in Thomas Whately's *Practical observations on the necrosis of the tibia* (1815): the plates display named patients' legs in various stages of ulceration.

Often, the need to be specific arose to argue or defend a medical point or argument. Although we are used to being persuaded by words, early-modern patient portraits were themselves powerful evidence in support of medical arguments. The portrait of John Heysham, who had ruptured his intestine at work, was taken precisely at the point when Cheselden was performing a procedure that required explaining (Figure 112):

> There had been a rupture of the omentum before, which being united to the scrotum and spermatic vessels, I passed a needle with a double ligature (as expressed in the plate) under that part of the omentum that adhered, so as not to hurt the spermatic vessels; then cutting out the needle, I tied one of the strings over the upper part of the omentum, and the other over the lower, and then cut off as much of it as was in the way. My reason for tying in this manner was to secure the blood-vessels, which, I think, could not be done so well with one ligature, because of the largeness of the adhesion...which renders it too liable to be torn by such a bandage...After he was cured, he first wore a small truss, but left it off in a short time, and now feels no convenience...though he lives by hard labour.[839]

Similarly, to persuade his readers of his arguments, Edward Harrison "selected and published nine cases treated according to the principles laid down" in his book on spinal diseases. He did not "hesitate...to declare the names of the sufferers". Harrison bade B. R. Green to draw and S. Bellin to engrave portraits of these named patients – most of whom were children – both before and after their treatment.[840] Like Hunter's portraits in the last

[839] Cheselden, *Anatomy of the Human Body*, 322-3, tab. 39.
[840] See Harrison, *Pathological and practical observations on spinal diseases*, 189ff, 205, 210-8, 223, 294.

chapter, these before and after portraits documented Harrison's positive intervention. They visibly vindicated his methods.

In promotions, the main benefit of using named patients' portraits was precisely that they confirmed a doctor's positive intervention. They regaled a doctor's good and successful relationship with his patients. Two patients of oculist Sir William Read – Elizabeth Hopkins and Mrs John Webb – had their portraits taken by M. Burghers as part of a suite of thirteen miniatures that surrounded an engraved portrait of Read (Figures 113 and 114).[841] Inscribed on Hopkins' portrait is the unashamedly self-promoting caption:

> He Cut off a very large Cancerated Breast from the Body of Elizabeth Hopkins of Oxford, in 1689, and perfectly Cured her: For that and many other considerable Cures, he hath a Testimonial from the Vice-Chancellor.

Mrs Webb's portrait even shows her bed-ridden under the presumably ineffectual care of another doctor, anticipating Read's intervention. The inscription reads: "He cur'd the wife of John Webb...of a Dead Palsey...after being a Years Bedridden, and restor'd her to the perfect Use of her Limbs." Read used both his own and his patients' portraits to assert his reputation. In fact, Read's use of portraits to promote his skills would become notorious. In 1711 he was mocked in a satirical set of portraits by Francis Hoffman, in a print of *The III Oculists of Great Britain*. In this print, a portrait of Mead (a caricature of a then-current engraving by Faithorne after Kneller) sat alongside those of Drs Henry Sacheverell and Roger Grant and a mock panegyric billing Read as "well skill'd in Sight".[842]

At the other end of our period, William Wright cured Hannah Thatcher of her deafness and dumbness. A demure portrait of Thatcher – in a bonnet and dress, drawn by Rose Drummond and engraved by J. Rogers – was included in an 1823 article in the

[841] WL 563327i, 563328i.
[842] BM Satires 1570.

Gentleman's Magazine that praised Wright as an example of a charitable gentlemanly healer.[843] Thatcher's portrait was only then published separately – a month after the magazine came out (Figure 115). The portrait included information – as per the article – highlighting Wright's charity, his successful treatment and, to boot, where potential clients might look him up: "*Miss Hannah Thatcher*, BORN DEAF AND DUMB who was presented to the late Queen Charlotte on acquiring the sense of Hearing & the Faculty of Speech under the treatment of MR. WRIGHT, her Majesty's Surgeon-Aurist with whom she resides in Princes Street, Hanover Square."[844]Thatcher's portrait chimes with that of Elizabeth Powis, which was made for William Sands Cox by Bradley after R. W. Leonard (see below). Powis had undergone amputation at the hip under Cox's knife and was portrayed in demure attire at peace after her operation; but the very *raison d'être* of the portrait was to record Cox's successful amputation.

Other adverts were more obviously commercially oriented, but still focussed on the doctor's ability to treat. John Taylor cured the blind boy William Taylor and had a portrait made of William holding a mirror to emphasise the outcome of his work. The inscription makes perfectly plain to anyone who may not have understood the mirror motif that "William Taylor...a boy of 8 years old [was] born blind and restored to sight in October 1751 by Mr John Taylor Oculist, in Hatton Garden, London...." Taylor even took the liberty of appending his trade-card to the portrait.[845] A portrait of Cowasjee, an Indian husbandman, painted by William Nutter and engraved by James Wales, appeared in Holborn print-shops in 1795 (Figure 116). Demonstrating how titles can be a cue to visual inference, the portrait was plainly entitled *A Singular Operation*. Indeed, it marked a successful rhinoplasty operation (on Cowasjee) by Thomas Cruso and James Findlay. It included a diagram of the operation and apparatus and did not hesitate to tell its viewers

[843] *Gentleman's Magazine*, July 1823, part VI, 9; copy in WL 17948i.
[844] WL 1911-5-10 (1882i).
[845] WL 16433i.

that "this operation is always successful".[846] In another example, Astley Cooper commissioned a lithograph to be made of William Jones, who underwent a successful hip-joint amputation, a particularly delicate and "formidable operation".[847] The case was written up in the *Lancet* in January 1824 (although Jones was not named). The lithograph was sold separately from May 1824 by Mr Cox, the bookseller to the London Hospitals. In promotional guises, patient portraits were clearly imagined to advance the reputation of the medic who had treated or cured patients. They best enabled viewers (potential clients) to *see* the success that medics wrought.

Recognising both the benefits to themselves and their work, and also the critical acumen of their intended readers, doctors stressed how keenly they had overseen the production of patient portraits. The majority of works that include portraits of patients include a prefatory remark about how the author had directly superintended his draughtsmen and engravers.[848]Prefatory remarks also vouched for portraits' quality. Richard Bright thought that "the execution of the Plates I can safely leave without one word of praise".[849] Some drawings could be so good as to convey by themselves what information a doctor wanted. Thomas Whately said that "the appearance [of one of his illustrations] ...needs no explanation" – at least not to him and he presumed not to his brethren.[850] Doctors' vouching for the quality of their draughtsmen's and engravers' work was a silent assertion of their own visual critical faculties (see the case-studies below).

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[846]WL 23414i.

[847]*Lancet*, 18th January, 1824, 95.

[848] Bright, *Medical Reports*, ix; Howship, *Practical Observations in surgery*, vii; Harrison, *Pathological and practical observations on spinal diseases*, 223 n.

[849] Bright, *Medical Reports*, ix.

[850]T. Whately, *Practical observation on the necrosis of the tibia* (London, 1815), 124-5.

If good quality named portraits gave lustre to a publication, then badly executed portraits tarnished it. The advantages of publishing patient portraits could be squandered if the portraits were artistically sub-standard. Reviewers of Willis's *Cutaneous Diseases* were disappointed by the "inferior...wretched" and "purplish" colouring of the plates, which brought down their whole assessment of the work. This judgment stemmed in part from the fact that "there is no class of diseases in which pictorial representation is more useful, or more necessary". Because representations were so central to this branch of medicine, the poor portraits detracted from the whole authority of the work.[851]

Moreover, a work's repute would suffer if portraits were made not just badly but unsuitably. Portraits made with too much artistic freedom exposed a work to the charges that it was too subjective and therefore less authoritative. One complaint of Joseph Maclise's *Surgical Anatomy* was that the dead faces peppering the volume looked like a portrait "gallery" rather than self-evident illustrations of individual cadavers, as Maclise had declared they would be.[852] Maclise's readers would have preferred he use another type of illustration; a portrait was just too subjective in that instance.

On occasion, the very inclusion of a patient portrait could seem improper and render it unsuitable. One way it could be improper was if it made the publication too expensive. William Sands Cox's *Memoir of the Amputation at the Hip Joint* (1845) was berated for being aimed at a wealthy and non-professional audience, thus putting it beyond the means of the very surgeons who would benefit most from it. Importantly, the frontispiece patient portrait was a focus of this criticism:

[851] *British and Foreign Medical Review*, 15 (1839), 239; *Medico-chirurgical Review*, 34 (1839), 519f.
[852] Caldwell, 'Animated Cadaver', 348-9.

> He [Cox] might at least have brought it out in the ordinary size, and at the ordinary expense of an octavo pamphlet.... What do the Prince Albert, the Earl Howe, and the scores of reverend and other gentry care for such an offering?... [T]he money expended on the copies provided for so large a number of non-professional men...has rendered [the work]...a novel and most effective method of puffing and glorifying himself, in the eyes of his non-professional friends. It is clearly for the non-professionals that the full-length portrait of pretty Elizabeth Powis has been prefixed as a frontispiece; as it is calculated to convey no tittle of information to surgeons; while the engraving and especially the colouring of it, in red, blue, pink, green and yellow, must have made a large hole in the treasure trove of the "poor patient" [for whose benefit the case was written up].[853]

In this instance, the very inclusion of Powis's portrait – because it made the work too expensive and was not made to convey any medical information – was thought to be superfluous and aggrandizing (Figure 117). This brought the whole work into disrepute. Reviewers levelled a similar charge against d'Alibert's *Descriptions des Maladies de la Peau* (first ed. 1806): that medical utility had been sacrificed to artistic merit.[854] We must not assume, therefore, that the inclusion of *any* portrait improved a publication. Illustrations had to suit the book. Sometimes portraits were just not considered a suitable type of illustration.

All these examples where portraits were criticised stand as evidence of the visual intelligence of readers of medical books. Readers were aware of the sophisticated media used by medical authors and illustrators. They were also aware of medical authors' strategies in appealing to their visual skills. Readers' commentary, like that on Cox's publication above, indicates that illustrations were used to establish a dialogue between medical authors and their readers. By activating visual skills and asserting their mastery of this particular branch of illustration, an author basically claimed his mastery of the accuracy

[853] *British and Foreign Medical Review*, 22 (1846), 114. Colouring was expensive. In the case of E. W. Tuson's *A supplement to Myology* (London, 2nd ed., 1828), a colour copy was 50% more expensive than a black-and-white copy.

[854] With this, cf. Palfreyman, 'Visualising Venereal Disease', 138-9.

and precision needed for individuated portraits, and his skill in being able to interpret such individuated images. In other words, a doctor claimed that "I can produce, see and interpret *x*, and I assume you can, too". This dialogue is most evident when patient portraits were not up to scratch or inappropriate, and readers answered back. As we move into the case-studies, we shall examine more strategies to connect the author's and his readers' visual skills as the cornerstone of their community of medical knowledge.

Summary

So far, we have seen that many medical publications in the long eighteenth century included portraits of patients. Making them and publishing them were manifestations of medics' desires to be as authoritative as they could be. Portraits denoted the status and appearance of bodies and body parts at precise moments in time – during the progress of a disease, at a certain point in an operation, etc.. They were invested with the eloquence to back up what medical authors wrote and to promote what they did. Often, these powers were assumed and thought to be obvious. And letting an illustration speak for itself, even "without one word of praise", was to assert one's own visual intelligence. Moreover, portraits bespoke medics' care and attention in investigation and analysis, so adding to their reliability.

In the final print editions, these mobilisations and the discussion of them skipped over the actual practices of making. The authority conferred on medics was wrapped up in references to artists' names and assertions of *their* skill. This point ties in with the points made above about general medical illustration. Authoritative and reliable were those practitioners who could not just make, but recognise, inspect and make use of good quality patient portraits. Remarks on such issues were another way of casting authors and readers as (a community of) guardians of medical visual intelligence.

Having considered some of the general ways in which authors and readers considered the matter of publishing patient portraits, it will help to test them against some case-studies, to drill into the way authors oversaw and profited from patient portraits. I take the case-studies chronologically, starting with Sir Alexander Morison.

Alexander Morison

Alexander Morison (1779-1866) was among the preeminent authors on mental conditions in the first half of the nineteenth century. As Michael Barfoot has shown, however, Morison's career is rather enigmatic.[855] He struggled in his early years to develop a practice of any kind, let alone in mental diseases. He relied on family ties and private wealth to tide him over. Eventually in 1810 he secured a post as the consulting physician to the Surrey Asylum and in 1835 to the Bethlam Hospital. He delivered private lectures on mental diseases, which William Munk claimed "did much to extend the knowledge of this difficult department".[856] Meanwhile, he curried favour with royalty, becoming physician-in-ordinary to Princess Charlotte of Wales and her husband, Leopold, for which services he was knighted in 1838.

The enigmatic nature of his practice has partly to do with the fact that there are few written sources describing it. His diary, the principal source for reconstructing his day-to-day practice, is plainly and stiffly written, and yields few practice patterns. The writing style of the few case notes that survive is equally flat.[857] Part of the enigma also lies in the fact that the interaction of practitioners and patients with mental problems was not conducted on the same terms as with a patient who had solely physical ailments. For instance, mental patients' relatives were the doctor's clients. Moreover, the moral principles governing

[855] M. Barfoot, 'Alexander Morison's Scottish Mental Disease Practice, 1808-31'; http://www.rcpe.ac.uk/streamingdemo/EHMG_Barfoot031208/launch.html; accessed 12th March, 2013.
[856] Munk, *Lives of the Fellows*, iii, 61.
[857] RCPL MS-MORIA/471.

interaction with mental patients centred on discipline, order and restriction:[858] putting these into practice did not require as much documentation as, say, bodily examinations.[859]

Besides the scanty manuscript sources, Morison wrote four books on mental illnesses.[860] Three were illustrated with portraits of patients. Morison, a disciple of physiognomy, believed these patients and their portraits bespoke and typified the mental conditions he discussed. We can therefore assess what Morison thought patient portraiture brought to his writings. In his early work, Morison tended to rely on the cases of other doctors, particularly Philippe Pinel and Etienne Esquirol in Paris.[861] Morison's later work, however, allows us to compare his own assistants' drawings with their equivalent 'worked up' publication plates. Besides some rudimentary comments from A. and M. Emery, Sander Gilman has made some very brief comparisons between these different phases. Gilman concluded that lithographs were used because they came closest to creating an illusion of fleeting, fugitive expressions, which Morison's readings of his French counterparts had encouraged.[862] Such expressions were pivotal to moveable-face physiognomy.[863] This provides a neat framing hypothesis for this case-study.

Morison saw three advantages in using portraits in his work. First, he thought portraits improved his (already published) lectures. Second, he thought portraits made it easier for his readers to comprehend the "varieties" of mental disease he exposed, and to distinguish between them.[864] Third, he maintained that portraits were the most effective means of inculcating the principles of physiognomy, which provided his theoretical ballast.

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858 Cf. A. Morison, *Cases of Mental Diseases, with Practical Observations on the Medical Treatment* (Edinburgh, 1828), 7ff.

859 See, e.g., Morison's 'Report of inspections of Houses for the Reception of insane persons in the County of Surrey 19, 22& 23 April 1828', in RCPL MS-MORIA/471.

860 A. Morison, *Outlines of Lectures on Mental Diseases* (Edinburgh, 1826); *idem*, *Cases of Mental Diseases* (Edinburgh, 1828); *idem*, *Physiognomy of Mental Diseases* (Edinburgh, 1840); A. Morison and T. C. Morison, *Outlines of Lectures on the Nature, Causes and Treatment of Insanity* (Edinburgh, 1848). Morison's diary does not appear to cover the periods of the books' publication (RCPE).

861 Morison, *Outlines of Lectures on Mental Diseases*, 131. E.g., RCPE MOR/4/59, 64, 88, 89, 162, 164, 165. See also Gilman, *Seeing the Insane*, 92.

862 Gilman, *Seeing the Insane*, 92, 100.

863 Emery and Emery, *Surgical and Medical Treatment in Art*, 68; Gilman, *Seeing the Insane*, 91-9.

864 Morison, *Outlines of Lectures on Mental Diseases*, 6, 40; *idem*, *Physiognomy of Mental Diseases*, 1.

As he said in *Outlines of Lectures on Mental Disease* (1826) and repeated almost verbatim in *Physiognomy of Mental Diseases* (1840, hereafter *Physiognomy*)

> The appearance of the face...is intimately connected with, and dependent upon, the state of the mind. The repetition of the same ideas and emotions...of the same movements of the muscles of the eyes, and of the face, give a peculiar expression...of those predominating emotions which characterize the different species of mental disorder... Besides this moveable physiognomy...other external signs have been suggested [by Gall, for instance]... The following series of Plates is intended to convey an idea of the moveable physiognomy.[865]

Portraits, indeed, would "give an idea of...descriptions of Mania". They could show mental conditions better than descriptions could convey them.[866] Indeed, Morison also averred that "the state of health [of an insane person] is to be ascertained more from his external appearance and expression...than from replies to questions". In other words, Morison thought the visual superseded the verbal in psychiatric diagnosis and analysis. It follows that he thought the proficient practitioner would be endowed with keen visual skills.[867]

Morison's preparatory drawings were made almost exclusively by three artists: François Rochard, Alexander Johnston and Charles Gow. Rochard made copies from Esquirol's patient sketches – taken at the Salpêtrière in Paris – from as early as 1826. It was from this stock that William Home Lizars made engravings for the first *Outlines* in 1826; these were widely praised for their fidelity to the expressions they sought to convey.[868]

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[865] Morison, *Outlines of Lectures on Mental Diseases*, 131. For his continuing commitment to physiognomy, see Morison, *Cases of Mental Diseases*, 3-4, and 'An Essay Upon the Morbid Appearances of Insanity and its Complications according to the best authors upon the subject', a MS essay penned in January 1846, in RCPL MS-MORIA/471.

[866] Morison, *Outlines of Lectures on Mental Diseases*, 138.

[867] Morison, 'Outlines of Lectures on Mental Diseases', 54.

[868] E.g. *Medico-chirurgical Review*, 10 (1827), 305. Morison did not explicitly explain why he borrowed Esquirol's cases, or why he chose Lizars. The fact that he did not have his own teaching post and therefore had no convenient access to his own cases goes some way to answering the first. On Lizars, see DNB; William was the son of Daniel Lizars, Morison's publisher.

Morison later commissioned Rochard at Bethlem Hospital in 1835. Rochard specialised in miniatures. His drawings are the smallest in scale of the three artists, requiring the examiner to peer far closer to them. Befitting a trained miniaturist, his drawings possess the finest yet clearest lines. They rely for their expressiveness on linear precision above any tone or colouring. Alexander Johnston was first commissioned in 1836. His and Rochard's drawings together form the stock for *Physiognomy*, also engraved by Lizars. Johnston earned his livelihood as a portrait and genre painter. His work for Morison was mainly composed in graphite. His compositions are rougher than Rochard's. Johnston exploited differences of tone and texture to generate the expressiveness of his sitters' faces.[869] Bold swathes of thick and hasty lines criss-cross his portraits. Clumps of intense strokes, marks of strong downward pressure on the pencil's flat plane, converge on certain facial features. His style generates particularly dramatic shadowing and a keen exposition of the angles and contours – not just the outlines – of the face. Morison first commissioned his third artist, Gow, in 1841. Gow's drawings make up the bulk of the preparatory studies for *Outlines of Lectures...* (1848). His style is different again. He preferred multimedia drawings: Gow often embellished his graphite sketches with dabs of white chalk or even pastel, lending them a sheen and palette unachievable with graphite alone.

As per Morison's physiognomic leanings, all three artists paid particular attention to patients' facial features. Rochard's drawings are almost exclusively of heads only, while the vast majority of the (total stock of) portraits are half lengths. Patients were portrayed in conventional poses. They were portrayed either frontally or obliquely, whereby full facial expressions were visible. Profiles were rare. Cases that warranted the closer portrayal of other features – for instance the hands – were uncommon and therefore worthy of more detailed artistic attention.[870] Most of the drawings are between quarto and folio size. Not all

[869] Arguably, these traits are exaggerated by the original coarseness and subsequent deterioration of his paper: much of it is now heavily yellowed and spotted.
[870] See e.g. RCPE MOR/4/187.

the drawings were signed at the point of production; though there are no obvious reasons for this pattern.

In both *Physiognomy* and *Outlines of Lectures...* (1848), the drawings appear not to have been greatly altered between drawing and printing (Figures 118-121). Although the size was standardised for obvious reasons, the idiosyncrasies of the original draughtsmanship are apparent – in style if not in texture. Morison's artists' signatures are still evident – albeit reversed – in *Physiognomy*. Despite this and the intermittent appending of W. H. Lizars' stamp, Morison claimed the drawings as his own work.[871] In *Outlines of Lectures...* (1848), however, Thomas Coutts Morison, Sir Alexander's son, editor and protégé, acknowledged the pair's artistic debts: "The plates at the end, illustrative of the physiognomy of the different varieties of mental diseases, have been drawn under the immediate direction and superintendence of my father and myself, by Mr. Charles Gow, to whom our thanks are due, for the very able and characteristic manner in which he has executed them."[872]It would be rash without more evidence to say that a change in attitude toward the importance of artists, or toward the value of claiming the portraiture as their own, had occurred in the eight years between the publications. It is possible, however, to infer a slight change of critical emphasis away from having sound artistic abilities oneself in favour of being able soundly to assess them in others.

The only exception to the general non-interference with the preparatory drawings is that some of them had written captions literally stuck on them (see Figure 122). This suggests that Morison worked on the captions independently of the manufacture of the drawings, even though they obviously appear side-by-side in the books and even though he claimed to keep a close eye on the drawings.[873] The relationship of the captions to the portraits is instructive, however. To begin with, they demonstrate a concern for the

[871] Morison, *Physiognomy of Mental Diseases*, 129.
[872] Morison and Morison, *Outline of Lectures on the Nature...*, preface.
[873] E.g. RCPE MOR/4/93; Morison, *Physiognomy of Mental Diseases*, plate 42; RCPE MOR/4/114; Morison, *Physiognomy of Mental Diseases*, plate 35.

accurate recording of the time at which the portraits were taken.[874] Secondly, in *Physiognomy*, each caption was headed as an "Explanation" of the plate. Yet Morison did not comment on what the reader actually saw on the page. Morison simply announced that each portrait depicts the patient "in" whatever mental condition he or she was supposed to embody. The physical manifestations of the condition – the appearance of the eyes, the shape of the mouth, the cocking or tilting of the head and so on – were left entirely for the viewer to deduce. By considering such details superfluous, or at least by omitting any pointers, Morison silently averred that he possesses – and deemed his reader to possess – the skills necessary to detect these manifestations. Determining how much information the reader-viewer received discloses to us what level of assumed knowledge the author thought – or perhaps hoped – the reader had.

So the captions united Morison and his readers in forcing them to use (or have used) visual skills. Moreover, most captions were written in the style of medical case notes. Short, fragmented sentences abound. In particular, they were written in the present tense. This encouraged the viewer to see the portrait that the caption describes as a *current* portrait. The inscription dragged it into the 'now'. This illusion of contemporaneity had the effect of making the portraits seem like the clinical portraits examined in chapter III.[875] Moreover, the linguistic style and economy rendered the portraits the key analytical evidence. Still further, Morison's published portraits – unembellished from their preparatory state – were made to look like everyday working portraits. They appeared just like those that, as chapter III argued, doctors habitually made. That is, they freeze-framed the skills and practices that any practitioner reading his book will have possessed and used – or will have aspired to possess and use – in everyday working medical life. In this respect, part of the value of the published portraits derived from how closely they matched ordinary clinical medical drawings.

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[874] See e.g. RCPE MOR/3/5/1.3; 3/7/5.5; 3/8/1.3; 3/8/2.3; 3/14/1.4; 4/206; 4/226-7.

[875] On the notion of 'contemporaneity' and its relevance to mid-nineteenth-century portraiture, see L. Nochlin, *Realism* (Harmondsworth, 1991), ch. 3.

This notion is reinforced by differences in the text-image blending. Whereas the portraits showing patients in their state of mental unrest have rather lengthy accompanying descriptions, 'cured' portraits have barely any annotations whatsoever. The vast majority of the captions of 'cured' portraits stated that the portrait showed the patient to be just that – "cured". Such a caption might also state for how long the patient had been cured and how his or her general behaviour had changed. The point is that the portrait itself invited the viewer to see how 'ill' and 'cured' look different. No textual prompt was needed – only the eye of the mental health expert.

A number of visual devices were employed to capture the typical differences between looking ill and looking cured (see Figures 118-121). Patients' hair went from being shown as dishevelled to being shown as well-kempt. Eyes became softer and less intense. Female patients went from wearing haggardly clothes to more seemly attire; when cured, they mainly wore dresses, but, importantly, sported scarves and bonnets, too – accoutrements of female decency.[876] Cured men were depicted with seemlier coats and neckerchiefs.[877] Indeed, the portraits invited the viewer to consider how the cured look suits the patient's sex and betokens their readiness for re-entry into mainstream society. The visual cues relate to boundaries of gendered social decency as well as mental instability. The very inclusion of such visual cues once again silently marks out Morison's eyes as those of the established expert (as well as a bastion of decency). And it is this authority, as William Hunter alluded to above, that stabilises the meaning and articulacy of the portraits.[878]

Although there is little direct evidence to support or deny Gilman's hypothesis on the specific benefits of lithography, Morison's interferences in and oversight of the artistic processes of working up drawings to his books permit at least four conclusions. First,

[876] C.f. e.g., RCPE MOR/4/26-7, 34-5, 41-2.
[877] C.f. e.g., RCPE MOR/4/6-8, 9-10, 25, 29, 53-4, 76-7.
[878] See Hunter, *Gravid Uterus*, preface. See also, S. Schaffer, 'Self-Evidence', *Critical Enquiry*, 18, 2 (1992), 327-362, at 330 for such collective authority among natural philosophers.

Morison believed that portraits were instructive. Second, Morison believed that art could express physiognomic differences between mental illness and soundness of mind. Third, Morison believed that a doctor's visual skills could be corroborated through his very interference in/oversight of the publication process. Fourth, Morison's printed portraits adopted the characteristics of 'working clinical portraits', including scanty annotations, which anticipated the visual skills that readers would bring to bear on looking at them.

Francis Sibson

Having examined portraits of patients whose conditions relied on the depiction of superficial features, we move to discuss portraits of patients whose internal features were the main interest. Francis Sibson's patient portraits were innately concerned with the very practices of illustrating books. Taken together with the preparatory diagrammatic portraits, they exemplify the sort of special care and attention required, and the special challenges that arose, in using portraits as illustrations. Indeed, Sibson developed methods for making his and others' illustrations more rigorous and reliable. Moreover, as a case-study that pushes the time-boundaries of our period, it allows us to think about how period-specific the concerns and methods of using patient portraiture in publications actually were.

Sibson (1814-76) rose to prominence for his work (to paraphrase his earliest paper) on the relative situation of the organs in varying states of health and disease.[879] This preoccupied him for much of his career. Over twenty years later, in the preface to his celebrated *Medical Anatomy* (1869), Sibson explained that he still thought that the "knowledge of the relative positions of the internal organs" was the largest lacuna in general medical teaching. Given the general tendency to focus on individual and isolated

[879] Munk, *Lives of the Fellows*, iv, 72-3; cf. DNB.

organs, which we have noted,[880] his volume accordingly aimed to present "the exact topography" of the body. Indeed

> the illustrations...represent the parts exactly as they were found after death.... In making these drawings, the Author employed mechanical aids, described in columns 1 and 85, by means of which he has been able to represent with precision every organ, with its external and internal relations, at each stage of the dissection.[881]

Sibson here refers to his use of mechanical aids. For many years, Sibson had grappled with the problem of how to allow for the upward movement and the shrinkage of the lungs on death, and also for respiration and the movements of the heart.[882] He made a breakthrough in about 1846:

> In pursuing the researches...I found the want of an instrument for accurately and minutely measuring the movements of respiration. About two years ago I succeeded, with the assistance of a patient in the Nottingham Hospital, and finally of Mr. Simmonds, in completing such an instrument. It...measur[es] the diameter of the chest, and indicating by the motion of the index on a dial any movement of respiration to the hundredth of an inch...[883]

With this device, he could begin to transfer his knowledge of the physical extent of bodily movement into his drawings:

> To assist in the inquiry of the movements of respiration, I have made diagrams from the dead – in health and in diseases – of the position of the ribs and internal organs, both

[880] Cf. chap. III; Bright, *Medical Reports*, i, ix.
[881] F. Sibson, *Medical anatomy* (London, 1869), preface.
[882] Sibson, *Medical Anatomy*, col. 73-7, 83, 84, 88.
[883] F. Sibson, 'On the Movement of Respiration in Disease, and on the use of a chest measurer', *Medico-chirurgical Transactions*, 31 (1848), 353-498, 354-5.

> before and after the complete inflation of the lungs. I traced the outline of the organs with chalk on a piece of black lace, stretched on a frame, and placed over the body. I transferred these outlines to paper, and reduced them by a pentagraph.[884]

This fabric-stretching method is remarkably akin to the practice of stretching canvas. By the time he came to writing up his researches, Sibson had developed a number of similar art-inspired cadaver-drawing methods. As he said of the first plate of *Medical Anatomy*:

> I took the outlines of the organs by the aid of a transparent tracing frame, suggested to me by Dr Hodgkin, on the plan described in my paper on the Situation of the Internal Organs in the Prov.[incial] Med. Trans. for 1844. Those outlines formed the groundwork for the coloured drawings from the body...[885]

As these comments might suggest, the preparatory drawings are extremely large. They were drawn in either very light pencil (the tracings) or in thick ink, with colour embellishments. They are rather schematic in style. Faces are not sketched with anything but outline details. Body outlines appear almost standardised, like blank templates (see Figure 123). In the preparatory phase at least, patient identity did not reside in the face or in anything superficial.

Many of these drafting techniques had to be dovetailed with precise dissecting methods that would preserve the 'solidity' of the cadaver. These, too, borrowed from practices and materials that were central to art. Plaster-of-Paris was commonly used for death masks, for instance:[886]

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[884] Sibson, 'On the Movements of Respiration in Disease', 356.
[885] Sibson, *Medical Anatomy*, plate 1.
[886] See M. Pointon, *Portrayal: and the Search for Identity*, ch. 5.

> I first exposed the ribs, vertebrae and superficial internal organs, as in Plate XII [(Figure 124)]. After taking a tracing of the parts so exposed, I embedded the face, neck, chest and pelvis, and the ribs and abdominal parietes, in Plaster-of-Paris. The ribs were then sawn across, and the spinal column was carefully removed. By adopting this plan, the internal organs kept their original position, and a solid prop was afforded to the ribs and abdominal parietes, which otherwise would have yielded outwards when deprived of their natural support. I advise the adoption of this plan to any one who may be induced to make for himself the very instructive series of dissections figured in these four plates representing the back view of the internal organs...[887]

And of plate XVI (Figure 125) Sibson explained that

> In this and the following Plates, the body is exhibited under two aspects. In Fig. 1, the lungs are collapsed as in expiration; in Fig. 2, they are inflated to the full, as in forced inspiration. In order that the lungs in Fig. 1 might retain the exact quantity of air that may be held after the last expiration, I inserted into the trachea a tube, the stop-tap of which was turned before opening the chest....it was difficult, and took a great deal of time to make the drawings in these plates. The difficulty lay not in the figures of the collapsed lung...but in those of the inflated lung...[because] the air escaped very gradually from the lungs, this necessitating a renewal of the inflation from time to time.... To lessen this source of error as much as possible, I took separate outlines of the body, both when the lungs were distended and collapsed, in the addition to those made for the actual drawings. When making the reduced drawings, constant reference was made, rib by rib, to those outlines, and to the costal walls...of each of the three bodies figured in these Plates. Every effort was made to attain accuracy, and I believe that these drawings are substantially correct.[888]

[887] Sibson, *Medical Anatomy*, plate 13, col. 49-50.
[888] Sibson, *Medical Anatomy*, plate 16, col. 61-2.

As the last sentence makes perfectly plain, Sibson's goal was maximum accuracy. All his methods and all the "great deal of time" dedicated to dissection and drawing were aimed at making the tricky task of portraying the human body as error-free as possible.

Importantly, Sibson understood art to supply the criteria by which accuracy could be gauged. One artistic criterion was scale. Sibson employed at least two means of reducing his drawings to an appropriate publishable scale without damaging the drawings' perspectival and geometric integrity: the pentagraph (or pantagraph) and "reduced squares".[889] (Although he used these techniques and instruments, Sibson's published volume was nevertheless an elephant folio edition.) The use of these devices had been broadly theorised in Britain toward the end of the eighteenth century.[890] The pentagraph even warranted an entry in Sir David Brewster's 1832 *Encyclopaedia*, where it was noted that it is "an extremely useful instrument to copy drawings".[891] Sibson's concern for accuracy of scale was so great that he specified – to within a tenth of the inch – the precise measurements of both the preparatory drawings and the final plates in the annotations to *Medical Anatomy*.

A second way Sibson could vouch for his portraits' accuracy was by acknowledging the skill of his artists and assistants.[892] He was scrupulous to mention anyone who had helped him – reinforcing the impression that many skilled hands had produced his work. He acknowledged the "untiring care" given to the preparatory colour drawings by William Fairland, whom Sibson closely supervised.[893] He acknowledged the "careful" colouring of

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[889] Sibson, *Medical Anatomy*, plate 6, col. 22.

[890] E.g. G. Adams, *Geometrical and graphical essays* (London, 1791), 379ff.; A. Bonamici, *Easy rules for taking a likeness by the most practicable principles of geometry and perspective with various analogous figures* (trans. [Abbé] Adams, London, 1792).

[891] J. Brewster, *Edinburgh Encyclopaedia* (Edinburgh, 18 vols.., 1830), vii, 744, and plate 238.

[892] The only person he did not personally acknowledge, but whose name in any case appears on the plates, was Charles Hullmandel and Joseph Walton – i.e., the printers. Hullmandel was almost twenty years deceased by the first publication of *Medical Anatomy*; and his erstwhile business partner, Walton, had ceased to trade by then, too. DNB.

[893] Sibson, *Medical Anatomy*, plate 1.

the final lithographs by Mr Sherwin.[894] He acknowledged the (unspecified) help of Messrs Paget, Filliter, Hodgkin, and Holmes Coote, too.[895]

As implied here, a third way Sibson could make his drawings as accurate as possible was by paying particular attention to colouring. (We noted above how important that could be for the experienced reader-viewer.) Sibson himself inscribed instructions on the preparatory drawings to confirm how they ought to appear, if they did not already look right.[896] At the bottom of Thomas Dedin's portrait, for instance, he noted that the "tumor [should be] more purple" (Figure 126).[897]

A fourth technique that Sibson implemented for accuracy's sake was showing with dotted lines how different organs would superimpose on each other (cf. Reichel's portrait of Peruntaloo in chap. III). Even if a particular angle or vantage point blocked the view of certain organs, the reader could imagine where they would be. It seems Sibson preferred to use dotted lines for the different organs rather than different colours, which he had used in the preparatory drawings (Figure 127).[898] The decision to publish the finished plates in colour may account for this; varying the line-style avoided a confusion of colours.

As Sibson indicated in his preface to *Medical Anatomy*, his illustrations were a means of representing "each stage of the dissection" of his patients' bodies. In other words, they were designed to be checkpoints at various points in the time-lag of dissection. Sibson had Fairland include in the final plates the dissection hooks used to keep the scalped skin back (Figure 128). These portraits were *openly* of cadavers that had been manipulated. Sibson trusted that if he could draw, and his readers could visibly comprehend, how the body

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894 Sibson, *Medical Anatomy*, plate 1.

895 Sibson, *Medical Anatomy*, plates 1, 2.

896 See e.g. RCPL MS-SIBSF/793/168. Sibson also left other instructions, too, including on whether or not to depict the face: *ibid.*, 793/281, 360.

897RCPL MS-SIBSF/793/189.

898 See e.g. Elizabeth Hussey's portrait, RCPL MS-SIBSF/793/216. Cf. Sibson, *Medical Anatomy*, plate 1, fig. 1-7, which "refer exclusively to a series of dotted lines which indicate the outlines of deeper organs".

changed across the time it took fully to dissect a cadaver, then his final illustrations would be the more reliable.[899]

Exact timings were also imperative to this end. Preparatory drawings indicated how the drawings were made at very precise points in time. Sylvia (?) Redgate's portrait was a composite picture of the positions of her organs (in both "ordinary" and "deep respiration") during various stages of her case of pericarditis and pleuritis between November 17th and 26th (of an unstated year) (Figure 129).[900] Eleanor Hooper's portrait was similar for showing various specific dates.[901] Emma Streeton's bronchitis and Miss Shaw's many complaints were dated precisely to August 22nd, 1847 and August 7th, 1845 respectively.[902] Sibson went so far as to state that Able Toples' portrait was "after [a] meal", while another was "taken immediately after breakfast".[903] Plates XVI-XVIII were taken first "just as it was when laid open", then "after the complete inflation of the lungs".[904]

So, instead of seeking to skip over the artistic steps involved, the main way in which Sibson tried to leap over the methodological hurdles of depicting the dead human form as accurately as possible was by being frank and open about the mediations he caused and that his drawings went through. Unlike many of the medics and 'scientists' that long eighteenth-century historians have studied up to now, Sibson did not try to feign the absence of mediation. Rather, he exhibited his control of mediating practices. In this respect, his practices grapple with some of the representational problems highlighted by wax anatomical modeller Frederick Knox in the 1830s and also anticipate the practices of the later nineteenth-century astronomers who debated the "personal equation" inherent in recording astronomical observations.[905]

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899 Sibson, *Medical Anatomy*, preface.
900 RCPL MS-SIBSF/793/164, 217.
901 RCPL MS-SIBSF/793/166.
902 RCPL MS-SIBSF/793/212-13, 233; cf. plate 23.
903 RCPL MS-SIBSF/793/219, 194.
904 Sibson, *Medical Anatomy*, col. 61.
905 Schaffer, 'Astronomers Mark Time'.

Even so, Sibson realised that he could only mediate so far. Drawings could not guide the reader-viewer all the way by themselves. Indeed, Sibson insisted, just like William Hunter above, that the viewer needed to possess visual skills in order to supply what art could not represent. Sibson avowed a decidedly comparative approach, and viewers had to be able to see comparatively.[906] The commentaries to his plates are full of 'spot-the-difference'-style cues to help the viewer understand how ostensibly very similar plates actually differed. For instance, "Plate II represents the same view as Plate I., except that the diaphragm is not removed, and the flaps are represented as they were in nature..."[907] Plate III is

> from the same body as Plate II. The sternum, and the ribs, and cartilage, in front, are removed, so as to show the anterior surface of the lungs and the superficial portion of the pericardium. Plate III. represents the superficial organs...

Of plate V, Sibson advised that although "the outlines of the ribs and sternum are not traced...they can easily be replaced by the mind's eye, by comparing this Plate with Plate IV".[908] Sibson thought a fully-functioning mind's eye was a fundamental part of the successful practitioner's medical anatomy. Only by combining the reader's keen eye for anatomy with the author's own masterly control of the mediations of dissected patients' portraits could knowledge of medical anatomy be gained.

Interim conclusions

Publishing patient portraits had significant implications for the works they were included in and hence for medical authors. Authors and readers recognised that patient portraits could

[906] See e.g. 'On the Movement of Respiration in Disease'. Every patient mentioned is named and compared.
[907] Sibson, *Medical Anatomy*, plate 2.
[908] Sibson, *Medical Anatomy*, plate 5.

lend added authority to a publication. This authority mainly rested on the prestige attached to the visual skills that were put to use – by authors in producing specific, individuated portraits, and by readers in viewing them. Publications channelled the collective visual skills of medical experts.[909] Not possessing these skills put one at a disadvantage when it came to transmitting or accessing the knowledge that books purported to contain.[910] Numerous artistic techniques were deployed to (try to) solve some of the thorny problems that portraying patients presented. For instance, Morison's explanatory captions attempted to overcome the 'time-lag' problem; his portraits relied on the extrapolation of general principles from individual facial likenesses. Sibson's dotted lines and comparative remarks attempted to overcome the problem of bodily fragmentation and were a key to his interference with particular bodies. It was not always a patient's complete identity, but his or her specificity or individuality or singularity that mattered in the publication of patient portraits.

Ultimately, the payoff for negotiating such challenges was that patient portraits were a highly eloquent kind of illustration. They could vindicate what a doctor was saying. They could demonstrate his past successful operations. They could be saturated with medical information. They could show the author and his readers to possess high visual intelligence – high enough, indeed, to interpret the signs of illness and morbidity on individual bodies (in Morison's case) or to generalise about the relative position of organs in *any* body (in Sibson's case). Such attributes of portrait illustrations were crucial to commercial as well as personal success; and their cachet persisted well into the second half of the nineteenth century.[911]

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[909] With this, cf. Kusukawa, *Picturing the Book of Nature*, 19-20.

[910] With this, cf. the notion of "hermeneutical epistemic injustice" developed by M. Fricker, *Epistemic Injustice: power and the ethics of knowing* (Oxford, 2007).

[911] See e.g., J. Hutchinson, *A Smaller Atlas of Illustrations of Clinical Surgery* (London, 1895), v-vi.

Portraiture and medical affinities

Having examined how patient portraits played a role in relationships between medical authors and their readers, the second part of this chapter considers other types of socio-medical relationships that portraits featured in. Why should portraits have featured in such historical relationships at all, and what exactly do they reveal about those relationships? What work did portraits do in medical relationships? In particular I examine how portraits expressed medical affinities between people. By medical affinities, I mean any association between people that was invested with a medical concern. I argue that portraits expressed these affinities not only by disclosing information, but also by being 'things' invested with emotional and cultural significances. These significances were generated as much from portraits' ability to stir feeling, kindle emotion and evoke kinship as from their ability to show any illness (cf. chap. I). I also argue that the work portraits did in expressing these affinities could *itself* be medical. They could even heal and restore. They were not just expressing what was medical about existing medical relationships, but could actually form a part of what was medical about those relationships.

Portraits and (inter)personal relationships

Historians have long been aware of the ability of portraiture to articulate what connects people and to carry emotional freight. The Duke of York gave Peter Lely a multiple commission to paint the duke's comrades of the Anglo-Dutch Wars. William Temple's collection of 'British Worthies' in his gardens at Stowe asserted his (self-) alignment with literary and philosophical dignitaries of his and previous ages. Sir Godfrey Kneller and his 'associate' engraver John Smith repeatedly portrayed one another holding each other's work in a series of portraits and engravings in the 1710s to commemorate their increasing professional symbiosis; such portraits were not just about the pair as individual sitters but

rather their close relationship (see Figure 130). Wedding photographs and ultrasound scans are modern examples of the emotional freighting of portraiture.

Sometimes, this freighting can suppress the individualizing tendency of portraiture. Marilyn Sreathern has shown how the Hagen clan of Papua New Guinea would actually disguise with accoutrements any representations that were too individuating, partly because their body features were supposed to reveal all the relationships a man had formed.[912] Kneller's well known suite of Kit-cat portraits depicted the members of that club in remarkably similar attire, similar poses, and even on an identical scale (the size of their portraits became known as the 'Kit-cat' size). These portraits were physical embodiments of their political and philosophical sympathies (see Figure 3).

As well as being commissioned, bought and sold, re-represented and re-worked in different media, portraits were also presented as gifts. Many contemporary commentators, such as the Swiss observer André Rouquet, noted the enormous traffic in portrait-gifts in eighteenth-century England.[913] Offering a portrait as a gift was a common way of loading it with personal esteem or a sense of cultural similarity between individuals (or groups). Neil de Marchi has shown that even within the art market this gift-exchange value was a recognised part of the "proper value" of portraiture.[914]

So the circumstances of portraits' production and afterlife – circumstances which arise from conscious effort – can tell us much about the 'work' that portraits did to create, sustain and articulate relationships between people.[915] (In this respect, portraits are just like other 'anthropo-cultural' artefacts.) The myriad meanings and associations that were generated as portraits were copied, displayed etc. are a part of this 'work'.

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912 M. Streathern, 'Pre-figured figures: a view from the Papua New Guinea highlands', in Woodall (ed.), *Portraiture*, 259-268, esp. 264.

913 Pears, *Discovery of Painting*, 36.

914 N. De Marchi, 'Introduction', in J. Warren and A. Turpin (eds.), *Auctions, Agents and Dealers: The Mechanisms of the Art Market 1660-1830* (Oxford, 2008), 1-10, at 1.

915 See esp. M. Pointon, *Hanging the Head: Portraiture and Social Formation in eighteenth-century England* (New Haven and London, 1993); Jordanova, *Defining Features*; cf. *eadem*, 'Cultural Effort: An Introductory Essay', in *eadem*, *Nature Displayed: Gender, Science and Medicine 1760-1820* (London and New York, 1999), 1-18; *eadem*, 'People, Portraits and Things: Richard Mead and Medical Identity', *History of Science*, 61 (2003), 293-313.

Unsurprisingly, medical men formed social relationships. The chartered medical colleges and the many voluntary hospitals of our period are just two institutional forms of early-modern medics' sociability (which happened to hinge on their occupational practices). Moreover, certain features of early-modern medical treatment, like correspondence, were inherently social. Indeed, it is worth reiterating from the Introduction that patient-hood was a social concept.

The relationships brought into being by patient-hood were complex. For one thing, we know they were conducted in many places: hospitals, the bedside, spa towns, etc.. They were conducted on varying terms. Privately engaged doctors were often selected on account of (pre-existing) patronage networks, family ties and cultural links (including religion) as much as by their medical prowess. Wealthy patients paid handsomely for doctors' services; the less fortunate often relied on charity, which some doctors, like William Oliver at Bath, were happy to oblige them with. Sometimes, as we shall see, what was 'medical' about the relationship between a patient and a doctor may have amounted only to a fraction of the connections between the two people, but that fraction could become more significant when other medical people were connected to a portrait via wider networks. There was a great traffic in portraiture within such relationships and throughout such networks. One way of thinking about what we are looking for is evidence of how portraits contributed to early-modern medical sociability.

What sort of medical relationship gave rise to patient portraits?

Given the innumerable ways in which relationships were formed, we must ask whether there were certain medical relationships that generated portraits. One reason for a portrait arose when a doctor had rendered specific noteworthy medical service. Indeed, portraits stood as tokens of gratitude and deference in this respect. We know that portraits of *doctors* could be motivated by a patient's gratitude. Hence John Russell's 1789 crayon portrait of

George III's physician, John Willis, which was commissioned by the king himself to thank Willis for curing his first bout of mental instability. Or hence Romney's (unfinished) portrait of Sir Richard Jebb, begun after Jebb saved him from an acute chill.[916] Portraits of doctors and patients together could also stem from such emotive experiences. In 1820, Francisco Goya portrayed himself with his doctor, S. Arrieta, who had saved his life not a year before.[917] An 1816 portrait of the Leeds surgeon William Hey was commissioned by Lady Harewood precisely because Hey had proved himself worthy of his reputation as a kindly and sympathetic doctor (Figure 131). As a test of his repute, Harewood had dressed up as a gypsy and taken a young child with a broken collarbone to see Hey, who received them both warmly. So impressed was Lady Harewood that she bade William Allan to paint the scene of Hey attending to the child with Harewood looking on incognita.[918]

Portraits of patients could even be prompted by doctors rendering (professional) services to other doctors. We saw earlier how Lam Qua's Chinese patient portraits could be used to drum up professional support (and money) for the medical missionary Peter Parker.[919] Astley Cooper, meanwhile, had a clinical portrait of John Adams sketched three times because a section of Adams' tumour had been removed by William Blizzard, and Blizzard had included the section among his donations to Cooper.[920] Adams' portrait stood as an expression of the mutual esteem of these colleagues.

The Introduction remarked that the gap in social standing and cultural outlook between a practitioner and his patients could be minimal. Portraits were used to invoke these similarities between doctors and their patients. Douglas, 8th duke of Hamilton, for

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916 J. Romney, *Memoirs of the life and works of George Romney* (London, 1830), 137-8.
917 L. J. Jordanova, 'The Body of the Artist', in T. Bond and J. Woodall (eds.), *Self-Portrait: Renaissance to Contemporary* (London, 2005), 42-55, at 45; cf. A. Bond, 'Performing the Self?', in Bond and Woodall (eds.), *Self-Portrait*, 31-9, at 39.
918 D. Chamberlain, 'Some Leeds Surgeons of the Past: Presidential Address delivered to the Surgical Section of the Royal Society of Medicine on 2nd November, 1949', in C. Wakeley (ed.), *Annals of the Royal College of Surgeons of England. Volume 6* (London, 1950), 369-90, at 372; N. Leadbetter and J. W. L. Puntis, 'William Hey (1736-1819) and child patient', *Archives of Diseases in Childhood*, 89 (2004), 901.
919 Heinrich, *The Afterlife of Images*, 44.
920 RCSEng MS0008/4/5/5, f. 318r.

instance, was portrayed several times with his physician, John Moore. The title of Jean Preud'homme's 1774 portrait of *Douglas 8th Duke Hamilton, on his Grand Tour with his Physician Dr John Moore and the Latter's Son John* refers explicitly to a medical relationship between the two men (Figure 132). The relaxed stances of the men and the backdrop of rolled-up drapery are typical of much eighteenth-century aristocratic portraiture. Both are portrayed as participants in the Grand Tour, that cross-continent voyage of intellectual discovery and intense cultural exposure; in fact, they were portrayed at Geneva, as the background painting indicates. Despite the promise of the title, the scene gives no visible clues to any relationship of medical care. Indeed, Moore's gesturing to the globe, pointing out the position of Britain, suggests he is there no less as a tutor and guide than as a physician.[921] The depiction of a globe, a key instrument in the education of eighteenth-century boys, certainly reinforces this impression.[922] Moore adopts a similarly magisterial gesture in a portrait of the same three sitters taken in Rome by Gavin Hamilton. The term 'physician' in Preud'homme's title seems knowingly to encompass Moore's wider involvements in Hamilton's life. The medical tag attaches precisely to signify the pair's generally close cultural association. Let us explore this point more fully for Alexander Pope.

Alexander Pope

As the Hamilton-and-Moore example demonstrated, medics and patients were men immersed in and connected by the wider cultures of their times. Medicine interweaved particularly intricately with a number of broader cultural yarns, as scholars such as Craig Hanson and Jenny Uglow have shown.[923] Professional medics moved comfortably in social networks that included natural philosophers, architects, musicians, mathematicians, poets

[921] C. Hornsby, 'Introduction, or, why travel?', in *eadem* (ed.), *The Impact of Italy: The Grand Tour and Beyond* (London, 2000), 1-18.
[922] J. H. Plumb, 'The New World of Children in the Eighteenth Century', *Past and Present*, 67 (1975), 72 (n. 34), 89, 94-5.
[923] Hanson, *English Virtuoso*; Uglow, *Lunar Men*.

and men of letters. However, medicine seemed to carry an unequal share of the identity-signifying burden in such networks. This is why Moore could comfortably be called a physician even when doing things unconnected with giving care. The concepts and categories of doctor-hood and patient-hood had a wide scope. They could be referred to explicitly or evoked implicitly in non-medical domains. Portraiture was a channel for the joint-invocation of these categories. This renders it a valuable way of exploring the resonance of medicine in culture.

A second way of exploring this interweaving is by pursuing how notions of patient-hood and doctor-hood were evoked among those who were not, professionally speaking, medics at all. Sitters could be portrayed explicitly *as* patients of those who were not doctors, but who nonetheless cared for them. Portraits can therefore help us to understand the medical involvement of non-doctors in medical care, and so to grasp the precise extent of how these contemporary medical categories were made manifest in day-to-day life.

The numerous portraits of Alexander Pope suggest questions that penetrate these two historical points. How and why did portraits circulate within cultural networks that included doctors and patients? What was the role of portraiture in relationships founded upon medical care?

Virtu

Earlier in this thesis, I suggested that some of Alexander Pope's portraits sought to cast him as a man of virtue. Virtue refuted deformity, I argued, because it identified its bearer as an exemplar of powerful eighteenth-century 'codes of conduct' like wittiness, probity, learning and so on. These codes were often subsumed under the broader rubric of *virtu*. This was an impulse of classically-inspired civic humanism that prevailed in 'polite' society from the sixteenth century onwards. It persisted, with the philosophical buttressing of Bacon, Locke and Shaftesbury in particular, well into the eighteenth century. It prescribed

an ethic, an etiquette and, as David Solkin and John Barrell have argued, an aesthetic.[924] Indeed, *virtu* commanded men to partake of all manner of aesthetic and intellectual pursuits. Among these were poetry, collecting curiosities, natural philosophy, antiquarianism, architecture, music – and portraiture. Moreover, virtuosi aspired to be men of deep and wide learning. They avoided conscious over-specialism. One contemporary biography of Dr Richard Pulteney – by a virtuosic doctor no less, William George Maton – explicitly mentioned that Pulteney partook of "occupations which may be considered as only remotely connected with his profession".[925]

As Craig Hanson has convincingly demonstrated, both artists and medical men were among those cultivated men who sought to be virtuosic in this sense.[926] Pope's friend the artist Jonathan Richardson was a devotee of Shaftesbury. Wealthy royal physician Richard Mead was a celebrated virtuoso. He sank his money in assembling a large collection of ancient sculpture and artefacts at his home off Great Ormond Street, and invited like-minded men – including Pope and Richardson – over for dinner to discuss their virtuosic pursuits. Pope also described himself as a man of "the Virtuoso-class".[927] He thought that his grotto's collection of minerals, for instance, fitted the virtuosic mould, and he invited doctor-virtuoso Sir Hans Sloane to analyse them as curiosities worthy of scholarly attention.[928]

Pope could count himself a part of many circles of acquaintance and friendship. Portraits and cultural artefacts, created by artists who were themselves segments of these circles, strengthened these links. Charles Jervas, for instance, painted both Dr John Arbuthnot and Pope. Both Jervas and Arbuthnot were apostrophised in Pope's longer

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924 Solkin, *Painting for Money*; Barrell, *Political Theory of Painting*.
925 'Memorials of the Late Richard Pulteney M.D.', 19, RCPL MS-MATOW/441.
926 Hanson, *English Virtuoso*, esp. ch. 5.
927 Pope to Oxford, 8th October, 1724 *Correspondence of Alexander Pope*, ii, 264.
928 Pope to Bolingbroke, 3rd September, 1740, *Correspondence of Alexander Pope*, iv, 262; Pope to Sloane, 30 March and 23 May, 1742, *Correspondence of Alexander Pope*, iv, 391.

verses. And Arbuthnot was part of the Scriblerus Club, whose meetings Pope attended while he stayed at Jervas' house in St. James's, London.

In a similar multi-media vein, portraits were used by Pope and members of the medical faculty and virtuoso community as the threads that created and secured their kinship. Some of Jonathan Richardson's (1666/7-1745) many portraits – he painted over forty different likenesses of Pope – articulated both his and Pope's association to the medical faculty and virtuoso community. In a half-length profile portrait painted in oil on canvas circa 1738, Pope sports a reddy-plum coat with a brown collar (Figure 133). His hair is dark brown, his lips a pinky red. His skin, as Bill Wimsatt described it, is "flesh tint sallow with heavy pink strokes in [the] cheek".[929] This rendition of the skin resembles Richardson's earlier laureate portrait of Pope, in which thick swathes of paint streak across his left cheek.[930] It also chimes with Joshua Reynolds' comments at Lord Harley's picture sale in 1742: "the muscles which ran across the cheek were so strongly marked as to appear like small cords".[931] The portrait was not made on Richardson's whim, however. Indeed, it was commissioned by Richard Mead. Then-owner Anne Way inscribed on the reverse in 1825 that "this portrait of Pope was taken from life by Richardson for Dr. Mead the Physician...." This portrait is almost certainly the one Pope referred to on January 4th 1737/8, when he wrote to Richardson that "I will come to you to morrow by eleven, to sit till one if you please, for the Drs picture."[932]

As hinted by Pope's reference to Mead's title, Pope was Mead's patient. There is plenty of evidence that reveals Mead's role as Pope's doctor. Indeed, Mead can well be called one of Pope's most trusted physicians. Pope sought and privileged Mead's opinion time after time. Pope's *Epistle to Arbuthnot*, composed in 1734 and deemed one of Pope's more autobiographically informative works, reads: "I'll do what MEAD and

[929] Wimsatt, *Portraits of Alexander Pope*, 206.
[930] NPG 1179.
[931] J. Prior, *Life of Edmond Malone, editor of Shakespeare* (London, 1830), 428-9.
[932] Pope to Richardson, 4th January, 1737/8, *Correspondence of Alexander Pope*, iv, 91.

CHESELDEN advise / To keep the Limbs and preserve these Eyes".[933] Pope's correspondence from 1739 onwards mentions Mead repeatedly.[934] This dating means that portraiture was among the first ways of recognising a medical relationship.

For all that Pope was Mead's patient, this portrait does not show Pope *as* Mead's patient – in much the same way as Pope did not refer to Mead *as* his doctor. The portrait is rather a material commemoration of Pope's, Richardson's and Mead's broader kinship, painted at a time when Mead was Pope's doctor. Pope's use of the term "Dr" points to the infusion of the medical into this wider cultural connection between commissioner, artist and sitter. This point gains force when we set the portrait in the context of Mead's ownership of Richardson *Popes*. We know that Mead possessed many portraits of Pope by Richardson and distributed them to others, including his medic son-in-law Edward Wilmot.[935]

Pope's ties to Richardson and medical men were more substantial that any one portrait might indicate. Richardson also painted William Cheselden for the Royal College of Surgeons. Cheselden aided Pope in his final years. Pope even claimed Cheselden knew his health better than any other practitioner.[936] Richardson painted Dr Richard Hale for the Royal College of Physicians. He painted the antiquarian, Martin Folkes. And he portrayed virtuoso-physician Hans Sloane, too. Richardson's series (it is not strictly a suite) of graphite-on-vellum drawings, executed in 1735-40, makes the link between Pope and the medico-virtuosic faculty especially clear (Figures 134-137).[937] The grouping consists of Pope, Sloane, Folkes and Cheselden. All four are bust length drawings. All four are similarly sized: they are all within 35mm in height, and 46mm in width, of each other; two of them (Folkes and Sloane) are within 5mm in both dimensions. All four depict their

[933] See P. Rogers (ed.), *The Alexander Pope Encyclopaedia* (Westport and London, 2004), 110, 191.
[934] See, e.g. *Correspondence of Alexander Pope*, iv, 200-6, 338, 461, 467, 484, 499, 522.
[935] For Mead's place in virtuosic circles, see Hanson, *English Virtuoso*, ch. 5, esp. 167ff.
[936] Pope to Duchess of Marlborough, n.d., *Correspondence of Alexander Pope*, iv, 497-8.
[937] The series is also touched on by C. Gibson-Wood, *Jonathan Richardson: Art Theorist of the English Enlightenment* (New Haven and London, 2000), 120ff.

sitters wearing headwear: Pope is bayed; Folkes and Sloane wear velvet caps; Cheselden sports a softly powdered wig. All four were drawn with denser strokes on the cheek, jaw and nose. Richardson aligned these men – like Kneller did the Kit-cats – by the overall uniformity of his compositions.

Richardson's series begs a comparison with the more consciously conceived and certainly very uniformly produced series of medals that Jean-Antoine Dassier struck in February 1740/1, which included Pope among them (Figure 138). Antiquarian and art critic George Vertue tells us that

> Dassier has published proposals for cutting several medals or dies – the portraitures of famous men living in England. Martin Folkes Esq. is done very like him...The subscription is four guineas for thirteen medals... Robert Barber, M.D....Martin Folkes...Richard Mead, M.D., Alexander Pope...Sir Hans Sloane, Abraham De Moivre. [They are] done from the life and are free and boldly cut but not so elaborately.nor so high finish.as others, there appears a little of the fa-presto [*sic*].[938]

A mathematician is portrayed in the same manner as a poet, as doctors, as an antiquarian – virtuosi to a man. Moreover, virtuosi themselves were invited to consume these portraits in a numismatic guise that would befit the classical societies these men desired to reconstruct.[939] Collecting and possessing medals of one another would not only fulfil two virtuosic urges (the desire to collect and the desire to emulate the Ancients), but would also underline their kinship as "famous men" of *virtu*. Vertue also went on to note that Mead and Pope had been part of another series, Lorenz Natter's stone gems. Natter's gems and Dassier's medals show that consuming portraits and other virtuosic pursuits (like collecting medals and objects of natural history) often intersected. Pope, in other words, was a nexus

[938] G. Vertue, *Vertue Note Books* (ed. H. M. Hake, K. A. Esdaile and G. S. H. Fox-Strangways, London, 6 vols., 1930-55), iii, 102-4.
[939] On the significance of medals, see Brown, *British Historical Medals*.

of virtuosic interlacings whose meanings could be teased out at various social and artefactual levels. Portraits provided virtuosi – who included doctors referred to with their MD qualification and their patients – with a convenient and intellectually relevant means by which to show their broad affinities and their "mutual emulation and esteem".[940]

Pope: patient-friend, patient-sitter

Pope was an ill man throughout his life, as we read earlier in chapter II. Pope discussed his health with all comers. George Sherburn, editor of his letters, erred when he said that health was a matter discussed out of "mere politeness".[941] On the contrary, it was a matter of deep concern for Pope and his friends. Health and well-being were crucial to friendship. Importantly, time and again Pope considered himself the patient of his friends, while his friends thought themselves Pope's physicians.[942] The concepts and categories of professional medical practice permeated and partly defined their friendship. One example of just how busily involved his friends could get in Pope's medical life is shown by an amusing vignette of a visit he paid in 1728 to his friends the Codringtons:

> I called at Sir William Codrington's, designing but for half a day...but found it impossible to get from thence till just now. My reception there will furnish matter for a letter to Mr. Bethel. It was perfectly in his spirit [see below]: all his sisters, in the first place, insisted I should take physic, preparatory to the waters, and truly I made use of the time, place, and persons, to that end. My Lady Cox, the first night I lay there, mixed my electuary, Lady Codrington pounded sulphur, Mrs. Bridget Bethel ordered broth. Lady Cox marched first up-stairs with the physic in a gallipot; Lady Codrington next, with a vial of oyle; Mrs.

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940 This phrase was used to describe the function of Richard Mead's dinners; cit. Hanson, *English Virtuoso*, 169.

941 *Correspondence of Alexander Pope*, iv, 79, n. 2.

942 See e.g., Pope to Swift, 30th August, 1726, *Correspondence of Alexander Pope*, ii, 393; Pope to Oxford, 16th March, 1731/2, *Correspondence of Alexander Pope*, iii, 278; Bathurst to Pope, *ibid.*, iii, 130, 299, 503-4.

> Bridget third, with pills; the fourth sister, with spoons and tea-cups. It would have rejoiced the ghost of Dr. Woodward to have beheld this procession...[943]

Friendship was also crucial to how Pope and his circle conceived of portraiture. Pope thought that sharing portraiture was among the sacraments of friendship, which would perpetuate its memory. As he gushed to Lord Harcourt in 1723:

> I shall not be in any way disappointed of the Honour you intend me, of filling a place in your Library with my Picture [by Kneller]... Give me leave... to thank you for so obliging a Thought, as thus to make me a Sharer in the Memory, as well as I was in the love of a Person...and thus to be Authorized by You to be called his Friend, after both of us shall be Dust.[944]

He was equally gushing to Jonathan Richardson of a portrait by Richardson of their friend Lord Bolingbroke: "It is hardly possible to tell you the joy your pencil gave me, in giving me another friend, so much the same [as he looks]".[945] Indeed, historians have realised that friendship is one of the widest channels of portrait traffic.[946]

Pope's circles thought that portraits could commemorate medical help in similar ways to those discussed above. Portraits could, for instance, enshrine the happy consequences of the help a doctor had given. John Arbuthnot, Pope's friend and physician, once said to Pope that "no body had a better Right to a Lady's good looks in a picture than her physician if he can procure them."[947]

To explore what Pope and his friends thought portraits could actually *do* in medical relationships between them, let us consider Pope's medical relationship with a single friend:

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[943] Pope to Martha Blount, 4th September, 1728, *Correspondence of Alexander Pope*, ii, 513-4.
[944] Pope to Harcourt, 22nd August, 1723, *Correspondence of Alexander Pope*, iii, 193.
[945] Pope to Richardson, n.d., *Correspondence of Alexander Pope*, iii, 326.
[946] Jordanova, *Look of the Past*, 188ff.
[947] Arbuthnot to Pope, n.d., *Correspondence of Alexander Pope*, ii, 196.

Hugh Bethel (?1648-1717), the brother of Lady Codrington. This relationship in fact centres on a portrait that was never actually made. Yet the background, context and preparation for the portrait show that friendship and health were pivotal to how the men thought about portraiture and what portraiture meant for their medical relationship.

Bethel was a Catholic friend of Pope's from Yorkshire. He was, like the majority of Pope's long-term friends, an extremely close medical confidant. Both men had an extensive knowledge of medical practitioners and their treatments. Each considered the other a relay of local medical news and knowledge.[948] The pair sought doctors' opinions on each other's behalf. For instance, Pope requested Bethel's full history so that he could pass it to Richard Mead.[949] Besides this, they continually offered each other their own advice and solace. In fact, Pope confided most of his ailments to Bethel: there is evidence of Pope describing at least a dozen ailments and the treatments of at least a handful of doctors.[950]

Portraits of the two men assumed poignant meanings in relation to their mutual medical support. In winter, 1740, Pope wrote to Bethel describing (yet another bout of) his "crazie health". He was in a "low dispirited way", with "constant Pain in my side" and "a difficulty of Urine". Only the fear of catching a cold dissuaded Pope from travelling to Yorkshire to seek Bethel's immanent solace. In place of his self, he decided that although

> Your friend [William] Kent...has sent you [Enoch] Zeeman's picture [of Pope] without any Alteration, for he says he cannot, or will not, mend it, but I must sit to him for another for you. Which you may be sure I shall readily do, whenever he will.[951]

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948 E.g., Pope to Bethel, 1st May, 1731, *Correspondence of Alexander Pope*, iii, 197: "Dr Burton will be obliged to you if you can procure him an Exact account from the Physicians at York, what several minerals the waters are impregnated with?"

949 Pope to Bethel, 14th April, 1741, *Correspondence of Alexander Pope*, iv, 338; same to same, 1st January, 1742/3, *ibid.*, iv, 375-6.

950 *Correspondence of Alexander Pope*, iii, 427, 435; ibid., iv, 85, 206, 253, 255, 269, 445, 473-4.

951 Pope to Bethel, 28th November, 1740, *Correspondence of Alexander Pope*, iv, 299.

Pope wanted to give Bethel another canvas substitute for his physical presence. This arrangement clearly depended on Kent being ready and willing. Alas he was not. Almost four years passed. Pope and Bethel continued to fret about each other's health (see above). Things changed in February 1743/4. After Pope had informed Bethel about an (eventually terminal) worsening of his dropsy and asthma, Bethel had sent Pope his portrait, pre-empting the Kent portrait. Pope's receipt of it shows how medicine and portraiture aligned in his mind:

> I went and conferred two whole hours with Dr Burton: he opiniatred the continuance of his Pills ... I persisted first & last in this Course 3 months with no effect ... till a week ago, I was seized with a violent Fit, & totally stopt from Expectorating...Mr Cheselden came to me at Battersea, where...[he] let me blood. I breathe, sleep & expectorate, without the Pills, yet they will have me take them on 6 in a day....I am inclined to keep bleeding, which Cheselden is confident I may. What do you think or know of this practise?...I ought not to finish this letter without acknowledging the Receit [*sic*] (just now) of your Picture....It is excellently printed, for it is exactly like you, and is well painted besides, I don [*sic*] know by whom or where? but it shall be before my eyes, in my Bedchamber, where I now pass much of my time.... If Kent will still put off my Picture, will you have a Copy of Vanloo's?[952]

Pope indeed kept Bethel's portrait in his bedchamber for the rest of his life.[953] In fact, it was the only one kept there. This physical situation, in the most intimate of locations, is significant to portraiture's emotional freighting in this instance. Bethel's portrait was like a talismanic reminder of his and Pope's mutual medical concern – an icon of their medical care visible to Pope in the very place where his medical life was playing itself out.

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[952] Pope to Bethel, 20th February, 1743/4, *Correspondence of Alexander Pope*, iv, 499-500.
[953] M. Mack, *The Garden and the City: Retirement and Politics in the Later Poetry of Pope, 1731-1743* (Toronto, Buffalo and London, 1969), 252.

Bethel for his part, in a gloomier and more self-mourning reply, explained that he gave his portrait to spare Pope the trouble of having to make a posthumous one. Having first compared Dr Burton's pills with those that George Cheyne had advised him to take, Bethel went on:

> The picture I ordered to be sent to you was done by a Painter in Rome.... I remembered your having your friend Mr [Robert] Digby drawn after his death... [and] I thought I would save you that trouble.[954]

Bethel conceived of it like an icon, a portal to the ever-living dead. It is also revealing that morbid despondency – or an ironic take on it – could prompt a sitter to give a portrait to someone whose treatment he was intimately involved in organising and discussing. Portraiture was like a coil between levels of medical concern in friendship – in this case, between medical care and morbidity (and perhaps death as well).

Having received Bethel's portrait (at the time without this explanation), Pope clearly thought he had to reciprocate. Presumably Pope imagined the van Loo copy would operate in the same way for Bethel as Bethel's portrait had done for him – as a token of thanks and a totem of support. This exemplifies how portraits could carry emotional freight beyond the point of first production.[955] Bethel already had a Kneller portrait of Pope. But Pope was so keen to send Bethel another portrait as soon as possible – in order to satisfy this particular and immediate emotional demand – that he gave up on Kent and looked to another artist altogether.

Pope's and Bethel's friendship did not necessarily turn on sharing health stories and lifestyle tips. They found all sorts of other affinities to one another, including their religion

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[954] Bethel to Pope, 25th March, 1744, *Correspondence of Alexander Pope*, iv, 511-2.

[955] For a more obviously religious example of this freighting, see T. Hunter, *An English Carmelite, the life of Catharine Burton...* (London, 1872), 256: "The Veneration I had for this Reverend Mother made me procure a medal, which after her death, I applied to her body, *which I still keep with great respect and esteem in my house*." Emphasis added. I am grateful to Sophie Mann for mentioning Burton to me.

and Pope's work. Yet it is telling that their desire to share portraits first coincided with a bout of "crazie health" and later crystallised when their mutual medical involvement became more intense. Not only could portraits commemorate this medical help, they could also be invested – perhaps like Roman Catholic icons – with power to bestow calm and courage on the afflicted, to bring ease to the diseased.

This section has shown that portraits could emanate from specific relationships which had a medical tinge. Pope and his friends were deeply concerned with each other's illnesses: they took pains to help where they could. Evidence suggests that, by their coincidence and context, portraits commemorated this especially medical aspect of friends' involvement in Pope's life.

Interim conclusions

Portraits are evidence of relationships. To the historian, portraits are the skeletons of relationships, the living bodies of which have long perished. The second part has shown how portraits were artefacts designed and made to mediate the shared cultural and sentimental interests generated by medical experiences. These mediations are traceable in the precise look and feel of a given portrait. For instance, to be portrayed in the same manner, or among the same series of portraits, as other sitters was to articulate a connection between the sitters. These mediations were often multimedia efforts: we saw that Pope's portraits, for instance, existed in a number of material cultural genres. Such mediations operated at numerous interpersonal levels, too – from between two close friends to among all self-styled virtuosi. Moreover, tracing patterns of portraits' reproductions and movement enables us to situate those connections within wider cultural domains.

This second part has also shown how portraiture was a material manifestation and articulation of what it was to offer care. In this respect, portraits are particularly useful

evidence for determining the scope of the notion of patient-hood. We have also seen that portraits confirmed relationships of care. All in all, they do not just reveal at one remove how medical relationships were conducted. Rather, they *were* one way of conducting them.

Conclusions

This chapter has used portraiture to interrogate how medical relationships were created and conducted. We have looked at a wide spectrum of medical relationships: between doctors via books; between friends; and between patients and practitioners who had wider cultural contact. We can describe these relationships as medical because mutual medical interests and concerns were at stake in all of them. The portraits that we have looked at were, depending on their context, either a way of illumining the interests/concerns at stake in a relationship (like medical knowledge and the ability to perceive medical art), or a way of resolving or fulfilling those interests/concerns.

Medical interests and concerns were of course extremely heterogeneous. They depended on who made up different relationships. Accordingly, it is difficult to plot change over time. It is certainly difficult, from our examples and case-studies, to contend fully with arguments like Meegan Kennedy's that posit a definite change over time in the nature of illustrative patient portraits.[956] I would sooner emphasise the structural similarity in the reasons for portraits' existence above any formal similarities in the portraits of a certain period. This better prompts us to think about the nature of the relationships themselves. Although their illustrations were remarkably formally different, the nature of the relationship between William Cheselden and his readers in 1740 was almost identical to that between Francis Sibson and his readers over a century later.[957]It is in noticing such patterns and running such comparisons that we can advance the broader historical claim

[956] Kennedy, 'The Ghost in the Clinic'.

[957]And it would be very interesting to compare these authors with those of the later nineteenth century who, as mentioned earlier, also relied heavily on portrait illustrations; Jonathan Hutchinson might be a case in point.

that portraits were pivotal to the very establishment and conduct of early-modern medical relationships.

Conclusion

This thesis began by setting out the methodological basis for using portraits of patients as primary sources in social histories of medicine and by setting out four historiographies that such portraits bear on. The four applications of this type of evidence suggest ways to advance these historiographies. They also suggest some avenues for further enquiry.

Hitherto, as far as it concerned the long eighteenth century, the phrase 'medical portraiture' had meant portraits of doctors. Scholars had used portraits as evidence to argue that doctors wanted to show certain features of their work and character – in short, of their identity. The first two chapters of this thesis quash any possible suggestion that the phrase can be confined – for the long eighteenth century as for any other period – just to portraits of doctors. Like doctors' portraits, portraits of patients and sufferers were also artistically deliberate, carefully thought-out visual artefacts designed to transmit information. Since portraits were a key means of generating personalised bodily likenesses, they were an apt way of depicting the bodily signs of suffering. They could also transmit information about the personal effects and understanding of illness. For instance, William Thompson understood smallpox as a way of promoting patience and the beneficence of Christ's healing. The sum of illness information perceptible in a portrait made illness an index of patients' and sufferers' identity. Moreover, portraits related to other representations of illness and bearers of information about identity, including other pictorial genres – such as satires – and texts.

Indeed, the first two chapters suggest that historians should pay heed to the full span of possible meanings of the term 'representation'. Long eighteenth-century society developed many multimedia ways of representing the effects of illness. Texts were by no means more important than visual sources in this venture. In fact, texts and visual genres were combined and blended in myriad ways. These combinations were not just designed to convey subjective accounts of the effects of illness on the body and character, however.

Rather, as expressive 'things' existing in a society of visually intelligent, 'interdisciplinary' people, portraits and texts were conceived as contributions to an on-going social dialogue about the meaning of cultural practices like visual interpretation, judgment and identity expression. In particular, portraits spoke to the relationship of the physical /visible to the non-physical/imaginary elements of these three matters. Because society had developed ways of judging and interpreting illness (like curiosity and physiognomy), illness representation was a channel through which judgment, identity expression etc. could be debated.

In this way, portraits of patients were, for patients, about asserting (self-) knowledge and one's own autonomous interpretation of illness and about refuting others' interpretations. In this respect, they were, following Sander Gilman, instruments of control. Portraits 'controlled' by representing illness in a certain way – by making illness look a certain way. Yet if representations conferred and expressed power and knowledge, knowledge and power equally influenced the choice of how to represent. These notions were and are intimately interwoven. Historically and historiographically, portraits of patients fuse(d) representation and power.

In fact, to paint a portrait that made an illness look a certain way was to invoke different powers and judgments. For instance, showing the signs of smallpox conferred on William Thompson the authority to be a moral guide; whereas, for William Hazlitt, it was about evoking the way he perceived his father. Melancholic portraits designated the strong working of the mind; whereas being portrayed 'straight' – literally and figuratively speaking – was deemed powerful enough to overturn a prior judgment of the sitter as deformed.

The first two chapters used notions like 'showing', 'looking' and 'front' to probe exactly how portraits were the expressive, social, communicative 'things' I have described them to be. Both 'showing' and 'front' were based on the development of motifs of illness and on alluding to illnesses in inscriptions and dedications and so on. 'Looking', meanwhile, referred to the audience's share in interpreting and perceiving the signs of ill-

health. How and to what extent portraits showed illness and looked ill depended on the focus of a portrait, the level of sitter scrutiny over the production of a portrait, circumstantial details like the intended context of reception (where it was to hang, what was to be read alongside it, etc.) and finally the visual skills that a viewer brought to bear on seeing a portrait. For instance, Humfrey Wanley's variable pock-marking depended on whether he was portrayed *as* an antiquarian scholar. Only the private (uncirculated) family portrait of Josiah Wedgwood disclosed his pockmarks and other signs of illness. George III, meanwhile, was powerless to intervene in his later portraits' production.

George's example showed how artists adapted conventional features of portraiture to convey illness. Indeed, it matters to the historiography of the representation of illness that no entirely new genre of 'ill portraiture' was created in the long eighteenth century. Rather 'ill portraits' were precisely those that tailored pre-existing portrait-making and portrait-seeing techniques to the facts of illness and patient-hood. In other words, illness was 'assimilated' by existing modes of representation and visual perception.

To argue that portraits were communicative is to imply relationships. I have already suggested that ill portraits were contributions to a dialogue. Indeed, the first two chapters underscored how the processes and decisions that informed a portrait's manufacture anticipated the fact that it would never be an isolated, detached image, but rather one embedded in and constitutive of social life and experience. To say that portraits were embedded in and constitutive of social life imputes to them a large significance: no less than the power to affect how contemporaries lived and acted with each other. I found the term 'mediation' helpful to connote the sorts of social powers and effects that portraits were invested with. And so, especially in the final two chapters, this thesis suggested numerous insights into the work that portraits of patients and sufferers did to mediate medical relationships.

Much work has been done on doctor-patient relationships – especially concerning the relative knowledge and relative power of each party. But such scholarship has got stuck

in using doctors and patients as the only two constituents of what is an unhelpful and limited binary model. Portraits can help in two ways. First, they reveal a more complicated set of relationships. And, having done so, they offer deeper insights into the implications of these relationships. The patient portraits discussed in chapters III and IV promoted the agency of others besides doctors and patients. Most obviously, these were medical assistants and/or draughtsmen, but we also considered printers and engravers. These agents affected the structure of clinical encounters, the dissemination of medical knowledge and the status of doctors – to isolate but three consequences. Engravers like William Lizars mediated the 'magisterial' relationship between Alexander Morison and his readers. A medical assistant like Jan Rymsdyk, in drawing his master's patients, gazed on John Hunter's patients differently from Hunter himself. More needs to be done to conceptualise the implications of this 'distributed' agency, not least because doctors themselves claimed their underlings' work as their own. We can nevertheless conclude for now that portraits reveal that patients were not unified objects of medical knowledge or attention. Rather, they were different kinds of objects, subject-matters and individuals according to whose eyes looked at them (let alone according to what their ailments were or to what social station they belonged to etc.). It follows that portraits also bear witness to a more complicated set of mediations – of knowledge, medical vision, client-patron 'deference', and so on – than has hitherto been recognised.

A second key (and related) component of the scholarship on medical relationships has concerned the medical knowledge which patients' examples were supposed to 'yield', specifically to practitioners themselves. Portraits of patients inscribed medical knowledge – much as illustrations inscribed natural philosophical, botanical and other proto-scientific knowledge in this period. Often, the medical knowledge patient portraits inscribed was specific to individual patients. Portraits could be patient-centric, not just about diseases. Indeed, portraits were a way for practitioners to understand how diseases and illnesses varied from person to person – how patients betokened specific pathologies. They

inscribed knowledge even to the point of exemplifying diseases, of being the chief means of recording and analysing cases, and of being the basis for group- and distance-evaluation. That portraits of patients were such a fundamental part of a doctor's way of working suggests that they are crucial evidence for the history of doctors as well as for the history of patients themselves (see below).

The fourth chapter showed that the inscription of knowledge in patient portraits was carefully managed. Visual knowledge could be taken as self-evident in publications. Indeed, medics prided themselves on being able to produce, oversee and most crucially scrutinise and interpret specific patient portraits. This self-evidence reinforced practitioners' claims to expertise. Publications have long been seen as a means to assert professional mastery of a subject. In another powerful example of the symbiosis of different sources, portraits complemented texts in the generation of medical expertise. Portraits provided medics with ways to vindicate their theories and arguments, for instance.

In this sense, in fact – reinforcing the point about their potential value in doctors' histories – portraits of patients are a conduit to practitioners' professionalization. We know that the ability to hone and use visual skills was a crucial component of professional medical practitioners' formation from at least the sixteenth century. If the third chapter revealed how portraits were crucial components of everyday clinical procedures (alongside case-notes and written reports), then (per chapter IV) publishing patient portraits demonstrated to the medical faculty and any other interested readers that the skills routinely practised in the intimacy of an operating table had been honed and mastered. In fact, precise artistic choices affected what skills were demonstrated and also those skills that readers themselves needed to access the knowledge contained in patient portraits. In other words, medics recognised that portraits could stake their claim to the skills of the expert

medic.[958] Thus portraits can link the everyday visual practices of practitioners with their efforts to cast themselves as experts. Both of these enterprises were vital to their standing as professional doctors.

A third component of the scholarship on medical relationships has concerned the way in which medicine penetrated wider social and cultural pursuits. Just like medical portraiture scholarship, this has mostly concerned doctors. Yet patients found kinship with their doctors in pursuit of *virtu*, for instance. The notions of doctor- and patient-hood were invoked in portraits to confirm this. Moreover, portraits of patients could even commemorate, sustain and embody medical relationships between patients and *non*-practitioners. This only strengthens the point that medical relationships *grosso modo* need not have operated only between patients and practitioners, let alone only in explicitly medical contexts, but in fact anywhere that medical interests or affinities existed. Indeed, portraits themselves could be a way to frame relationships as medical. So if they are not sensitive to portraiture, historians might completely ignore the many medical relationships that were formed and experienced in portraits.

As well as on the history of doctors and medical relationships, portraits of patients – perhaps needless to say – bear exceedingly profitably on the history of patients themselves. The first, second and fourth chapters all revealed how portraits mediated the facts of illness and generated (inter-)personal meaning about illness. Deciding to show pockmarks, for instance, is one gauge of how deeply felt the matter of being marked on the body actually was. Being presented as elegant and gentlemanly – as opposed to like a child – is one gauge of what it meant for Josef Boruwlaski to be tarred with the brush of deformity. His desire to send a portrait to Hugh Bethel is one gauge of what Alexander Pope thought portraits could do for ill people. So may portraits be evidence of the patient's view of illness (in many of its historiographical guises).

[958] For other material cultural examples of this sort of process, see A. Maerker, *Model Experts: Wax Anatomies and Enlightenment in Florence and Vienna, 1775-1815* (Manchester, 2011); Palfreyman, 'Visualising Venereal Disease', ch. 5.

However, strictly speaking, what patients' portraits supply are a 'views-of-the-patient' history of medicine, rather than a 'patient's-view' history of medicine. It is important to recognise how portraits offer a perspective at one remove from a strictly patient's-view history. Yet rather than taking us away from patient's subjectivity, this distance can be beneficial. Doing away with the need for any (implicit or explicit) patient's-view/doctor's-view dichotomy helps the historian to unite – rather than separate – themes such as agency, representation, power and knowledge. We have already said how portraits were sites for the interweaving of these themes; they also provide an analytical vantage that reflects this.

The distance also prompts historians to confer due agency on patients, doctors, medical personnel, artists, readers and general viewers (see above) – i.e. to consider intersubjectivity.[959] This, too, renders patient portraits sources that allow the historian to examine the relationship between a number of themes and a number of people at once – to examine them, indeed, in an intermeshed way, which better conveys how they were inextricably linked by contemporaries. John Thomson's battlefield sketches, for instance, reveal at once the history of his medical enquiry and the differences between his patients' wounded identities.

As well as bearing on these historiographies, the thesis has also demonstrated some over-arching methodological claims. These are worth evaluating, because they point to some of the potential limits of this type of study, and hence to some ways to develop it.

One particular claim this thesis makes is for the importance of portraiture as distinct from other image genres. We recall that the Introduction explained how historians of medicine had often been unspecific about the categories of 'image' and 'visual' material they use, what analytical purchase each had, and how different genres may have had different salience. The thesis borrowed a wide (contemporary) definition of portraiture, which understood, for instance, body fragments and representations of any identifiable

[959] This, moreover, is something that art historical scholarship has proven particular useful for in general.

person. These characteristics have founded a number of arguments, including, for instance, that portraits of patients' body parts exemplified diseases for doctors.

One of the central claims arising directly from this focus on personal portraits has been that portraits were, for sitters, crucial to the expression of illness based identity. Yet we have looked at portraits in a number of different guises: in satires, as illustrations, in different media, and so on. It is entirely possible that even the genre of portraiture is too broad to make sense of the variety and complexity of long eighteenth-century medical themes. Take Alexander Pope's iconography again. We saw that three-dimensional busts and (satirical) statues were particular prominent in judging his character. Yet he used a lot of two-dimensional portraits – especially profiles – to rebut these judgments. Did this distinction have a bearing on illness representation, and if so, what was it?

Another central claim – made in chapter IV in particular – is that personal portraits were a special kind of illustration. Personal portraits enabled or even required viewers to interpret specific and individuated images, rather than generic and impersonal ones. But even specific and individuated portrait-illustrations often came with varying degrees of identification in books. Alexander Morison often only included the initials of his patients, even though he knew exactly who they were and even though physiognomic method privileged interpreting an individual's features; whereas William Cheselden, for instance, mentioned John Heysham by his full name even though the operation Heysham's portrait related to was not unique to him at all. Consent was one consideration in identification, but what were the implications of varying levels of identification on readers' engagement with patient portraits? Were fully identified portraits more convincing?

A second over-arching methodological claim has been that historians relegate visual evidence in general and portraiture in particular – and rely on textual evidence – at the peril of upsetting the contemporary balance of evidence. Hence this thesis has found it most fruitful to use portraits wholeheartedly as primary evidence, not just as ancillary evidence, but equally to use portraits alongside other evidence – i.e. to complement portraits with

texts (and other material cultural and visual evidence) as appropriate. Indeed, these methods seek to approach the assumed interdisciplinarity that those of the long eighteenth century naturally pursued. Any use of text as ballast for the arguments from portraiture – i.e. anywhere that text has backed up visual inferences – is simply made in this spirit. This thesis has shown some of the payoffs to be gained from considering text and visual materials as mutually supporting. It would nonetheless be exceedingly profitable to continue to pursue the precise qualities that contemporaries invested visual and textual materials with.

One of the rewards for this might be a greater ability to compare across time, something which the case-study approach has limited. Indeed, the broad temporal span of the thesis begs important questions about the *longue-durée* significance of patient portraits. Many historians' work, like Emma Chambers' and Kelly Joyce's, suggests that patient portraiture continued to be highly valued in identity representation, clinical work and medical publication well beyond our period. But only by comparing manually executed portraits with photographs, X-rays, ECG and MRI scans – not to mention cinematic or musical media – could we evaluate the nature of such ruptures or continuities. For instance, one point of continuity might be in the realm of medical education . Medical pedagogy seems an important continual motivation for the production of patients portraits. What was the role of producing portraits of cadavers or live patients, say, in the teaching of medical students and the training of medical vision? We saw in chapter III a few instances of teachers' commenting on assistants' portraits, and we know that Charles Bell's lavish watercolour paintings of the war wounded were made specifically to teach posterity. How might these compare with computer-generated text-book diagrams of the twentieth and twenty-first centuries?

Addressing the change-over-time question is just one way in which the work of this thesis could be carried forward. But there are others. Given the importance of religion to matters of health – alluded to in the Introduction – it would be interesting to know how

changing attitudes towards iconoclasm, Christ's Passion, providence and religion in general affected the portrayal of suffering and the development of visual tropes of suffering. William Thompson's example suggested how religion might infuse into the notions of illness-related forbearance and stoicism. But just how did contemporaries draw on religious motifs to depict suffering and ill-health? Were Job's boils and Christ's stigmata – the latter visible in churches up and down the land – the only visual referents?

Long eighteenth-century portraits of doctors have been studied. So, now, have long eighteenth-century portraits of patients begun to be studied. Another way to extend the findings of this thesis would be to compare such portraits with patients' portraits of doctors – like Richard Dadd's *Alexander Morison* (1852) – or patients' portraits of patients (akin to some of those made at the Crichton asylum in the later nineteenth century).[960] With such comparisons, we can flesh out any *longue-durée* work on patient portraits and ultimately ask what has been the significance of medical portraiture, in all its forms, across different periods.

Whatever possibilities exist for future work, it will be made possible by letting portraiture in general – and portraiture of patients and sufferers in particular – flow in the mainstream of the history of medicine.

[960] See, e.g., Dumfries Archive and Record Centre, 1984 series.

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Figure 1: P. Mercier, *The Sense of Sight*, 1747, oil on canvas, 1321 x 1537mm.

Figure 2: J. Wright, *An Experiment on a Bird in the Air Pump*, 1768, oil on canvas, 1830 x 2440mm.

Figure 3: A view of Room 9 of the NPG, which displays half of the Kit-cat Club's members' portraits.

Figure 4: J. Reynolds, *John Hunter*, 1786-9, oil on canvas, 1400 x 1100mm.

Figure 5: J. Reynolds, *William Pulteney, 1st Earl of Bath*, 1761, oil on canvas, 1549 x 1473mm.

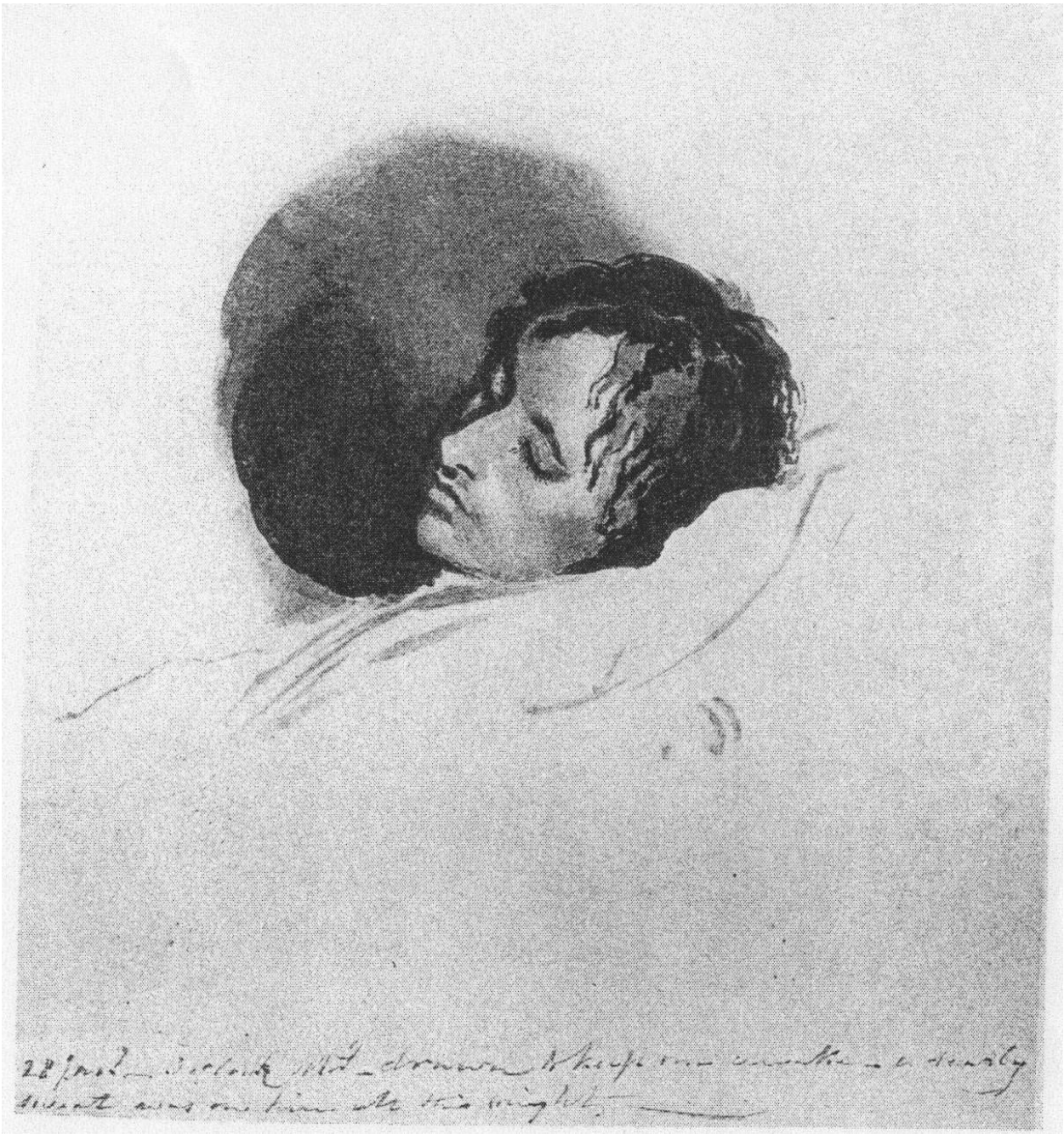


Figure 6: J. Severn, *John Keats*, 1821, pen and wash, 160mm x 120mm (copy).

Figure 7: G. Kirtland, *Smallpox pustules* (day 2)1802, watercolour on paper, WL MS3115.

Figure 8: G. Kirtland, *Smallpox pustules* (day 9), 1802, watercolour on paper, WL MS3115.

Figure 9: G. Kirtland, *Smallpox pustules* (day 16), 1802, watercolour on paper, WL MS3115.

Numb. 7379.

The London Gazette.

Published by Authority.

From Saturday February 22. to Tuesday February 25. 1734.

Berlin, February 16, N. S.

THE two Courts of Prussia and Bevern came hither Yesterday in the Evening from Potsdam.

Hamburg, March 1. N. S. Here is a Report, that his Danish Majesty is dangerously ill of the Small Pox. M. Bestuchef, who resided formerly in this Town, and is now appointed by the Czarina to succeed M. Brackel at the Court of Denmark, arrived here on the 27th past from Petersbourg, and will set out in a Week or ten Days for Copenhagen.

Hague, March 4, N. S. The Assembly of the States of Holland remains fixed for the 18th Instant, unless some extraordinary Affairs should require their meeting sooner. M. Van Borselen, one of the Deputies of Zealand to the States General, and formerly Envoy Extraordinary at the Court of Great Britain, is dangerously ill of a Fever. Yesterday the Ambassadour from Spain paid his first Visit to his most Serene Highness the Prince of Orange, which his Highness returned his Excellency this Morning. Couriers have been dispatched to their several Courts by the Ministers of the Powers that are engaged in the present War, with the Plan of Accommodation, which has been communicated to them.

Whitehall, February 21, 1734-5.

Whereas it has been represented to the King, that John Jones, *a Carpenter by Trade, about Five Feet and an half high, fresh-colour'd, Pockbolder in his Face, and wears a brown Wig, aged about Twenty Five Years, and born at Hackney in Middlesex, where he lately resided, was concern'd (with Jaffer Gregory, now in Chelmsford Gaol, and Two others) in entring the House of Mr. Gladdon, at Chingford-Green in Essex, and robbing the same in December last: His Majesty, for the better discovering and bringing the said John Jones to Justice, is pleased to promise a Reward of Fifty Pounds to any Person or Persons who shall discover the said Criminal, so as he may be apprehended and committed thereof, to be paid upon such Conviction.*

HARRINGTON.

The Persons undermentioned are charged upon Oath for committing several Robberies in Essex, Middlesex, Surry, and Kent, and are not yet taken, for each of whom a Reward of Fifty Pounds is advertised in the Gazettes of the 4th and 7th of January last past, and of the 8th and 11th of this Instant February.

Samuel Gregory, lodged lately at *Joseph Gregory's* his Brother's, a Carman, in Old Gravel-Lane, Radcliff. He is about Five Feet Seven Inches high, has a Scar about an Inch and half long in his right Cheek, is fresh colour'd, wears a brown Wig, and about 28 Years old, is a Smith or Farrier by Trade.

Thomas Rowton, lived lately at Radcliff Highway, towards the lower End by Shadwell Church, is a little Man, well-set, fresh colour'd and full faced, has small Pockholes in his Face, wears a Blue Grey Coat, and a light Wig, a Pewterer by Trade, aged about Thirty Years.

Herbert Hulser, a Barber or Perriwig maker by Trade, kept a Barber's Shop in Hog-Lane, in Shoreditch; he is about Five Feet Seven Inches high, of a pale Complexion, wears a brown Wig, and a Brick colour'd Cloth Coat, aged about 24 Years.

Richard Turpin, a Butcher by Trade, is a tall fresh colour'd Man, very much mark'd with the Small Pox, about 26 Years of Age, above Five Feet Nine Inches high, lived some Time ago at White-chapel, and did lately Lodge somewhere about Millbank, Westminster, wears a New Grey Coat, and a light natural Wig.

The following Persons are in Custody, viz.

John Wheeler, in New Prison.

Joseph Rose, Humphrey Walker, John Frisler, and William Saunders, alias Saunderson, alias Sebastian, in Newgate.

Jaffer Gregory, in Chelmsford Gaol.

Mary Johnson, alias Frazier, alias Rose, committed to the Gatehouse Westminster, as being accessary in receiving the Goods knowing them to be Stolen.

Pursuant to an Order of the House of Lords, Notice is hereby given, that a Bill, intituled, An Act for inclosing the Common Fields, Common Meadows, and other Commonable Lands in the Parish of Nuneaton alias Nuneaton, in the County of Warwick, is commitred to a Committee of Lords, who are to meet on Wednesday the 6th Day of March next, at Ten a Clock in the Forenoon, in the Prince's Lodging over the House of Peers.

London, Feb. 22, 1734.

Notice is hereby given, that a General Court of Election of the Governor and Company for making of Mines, Minerals, and Metals, in that Part of Great Britain called Scotland, will be held at the Sun-Fire Office behind the Royal Exchange, on Thursday the 29th of March next, from Ten of the Clock in the Morning till Two in the Afternoon, in order to chuse a Governor, Deputy-Governor, and Court of Directors for the New ensuing.

The Court of Assistants of the Russia Company give Notice, That the Annual General Court of the said Company will be held at Sadlers Hall, in St. Swithin's Lane, Cannon-Street, on Saturday the Last Day of March next, at Ten a Clock in the Forenoon, for the Election of a Governor, Consuls, and Assistants, and other Officers for the Year ensuing. By Order of the Court of Assistants. Thomas Hawes, Secr.

Adv.

Figure 10: *The London Gazette,* February 22nd 1734 (facsimile copy).

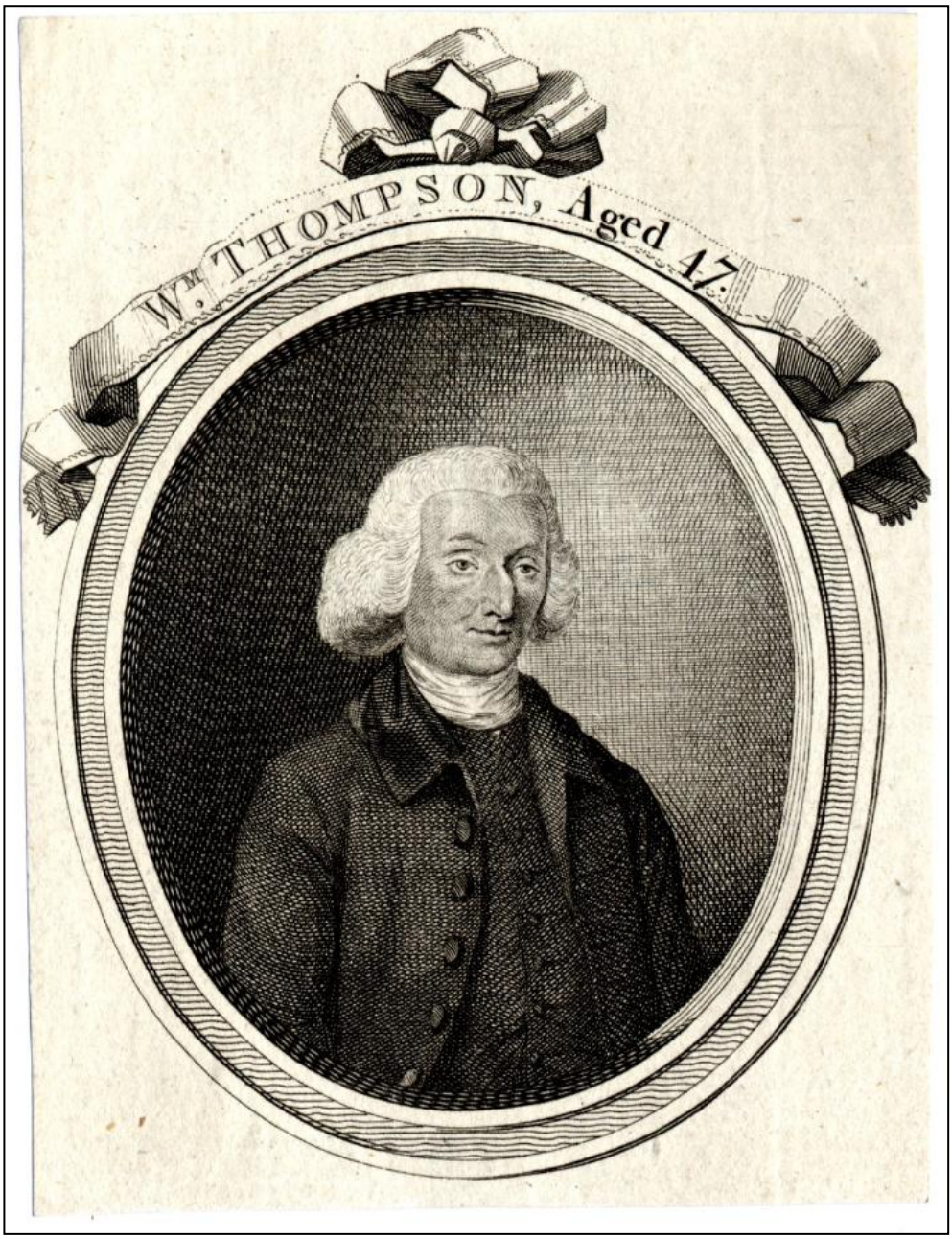


Figure 11: Anon., *William Thompson*, c. 1759, line engraving and etching, 126mm x 94mm.

Figure 12: P. P. Rubens (after?), *S. IOB PROPHETA,* c. 1680, line engraving, 204 x 195mm.

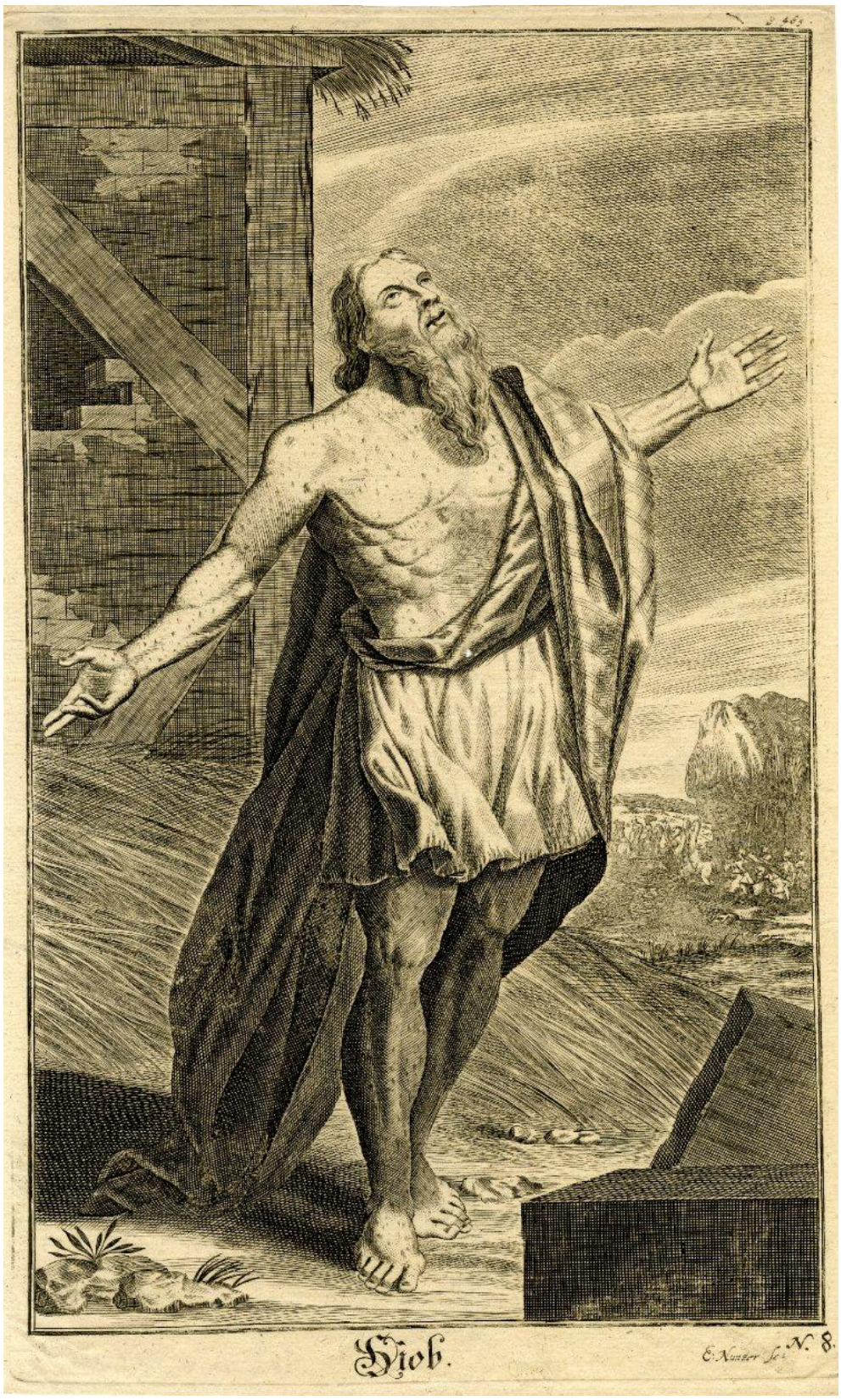


Figure 13: E. Nunzer, *Hiob,* 1733, etching on paper, 323 x 200mm.

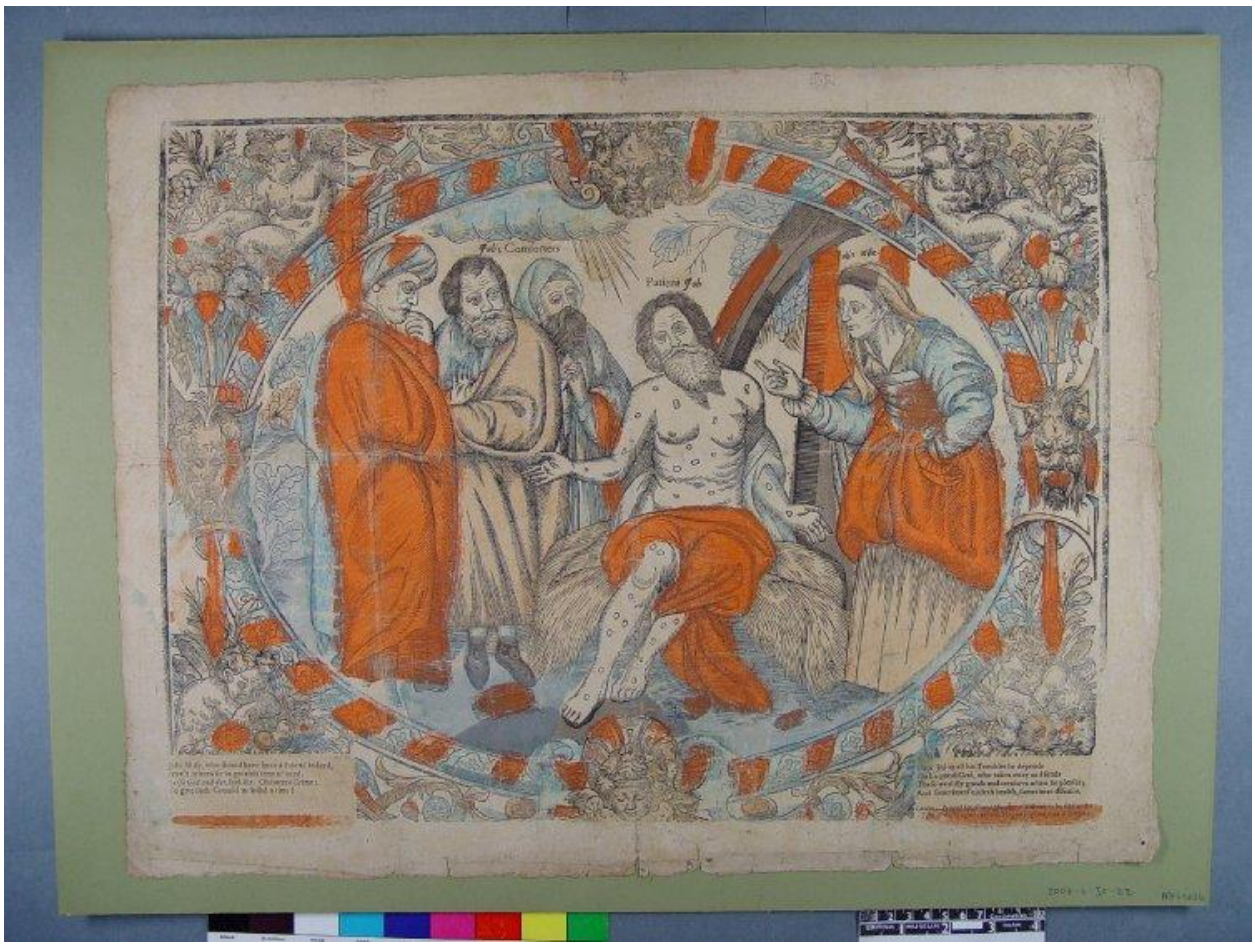


Figure 14: G. Minnikin, *Untitled,* 1690, woodcut and stencil press, 379 x 510mm.

Figure 15: F. Aspruck, 'PATIENTIA', from *Allegorical and sacred subjects, and hermits* (1740), f. 68r.

Figure 16: T. Hill, *Humfrey Wanley*, 1711, oil on canvas, 1219 x 1016mm.

Figure 17: T. Hill, *Humfrey Wanley*, 1717, oil on canvas, 762 x 635mm.

Figure 18: T. Hill, *Humfrey Wanley*, 1722, oil on canvas, 1430 x 1144mm.

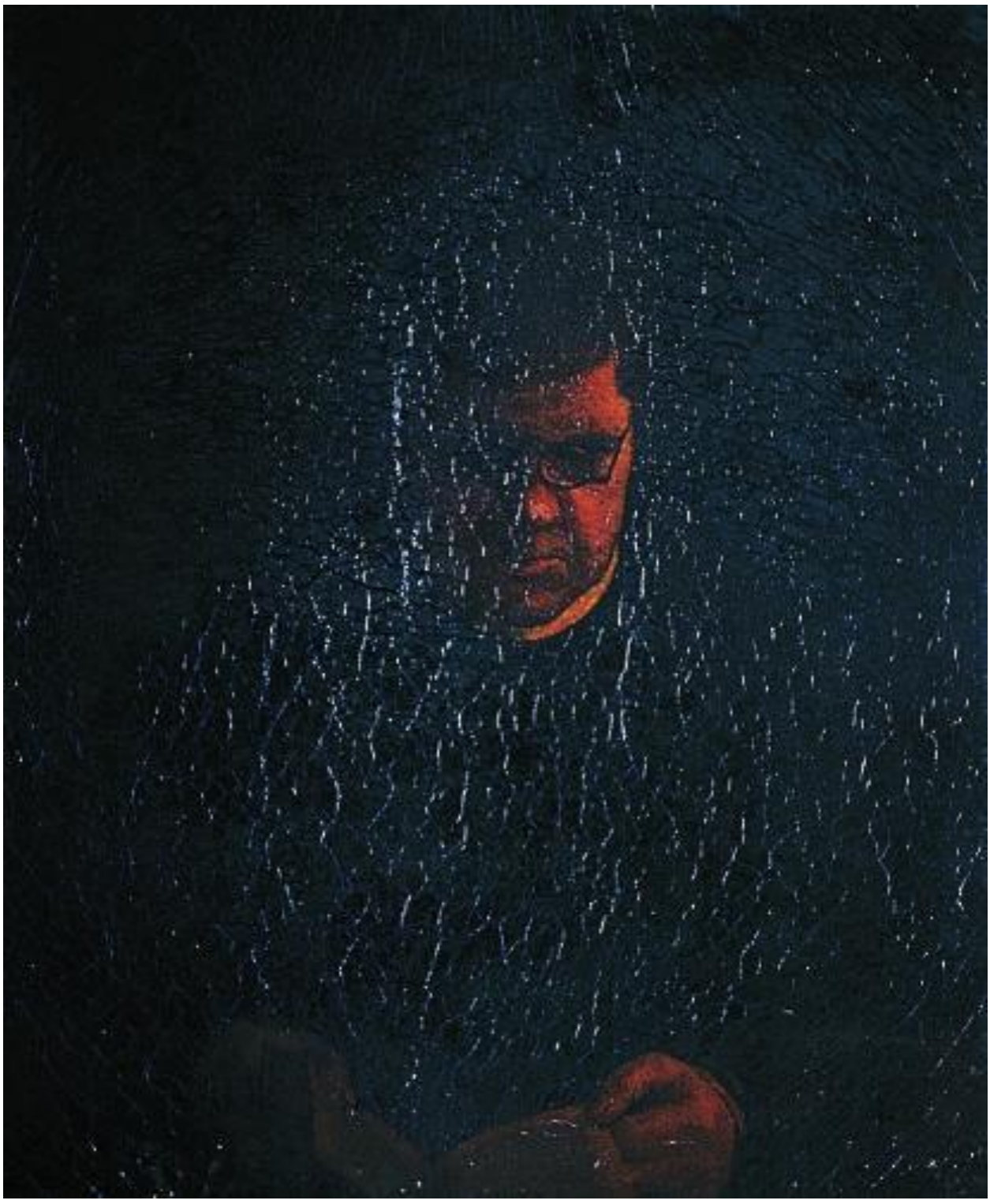


Figure 19: W. Hazlitt, *Rev. William Hazlitt*, 1802, oil on canvas, 750 x 630mm.

Figure 20: G. Stubbs, *Josiah Wedgwood and his family at Etruria Hall*, 1780, oil on board, 2130 x 1490mm.

Figure 21: Bedford Armorial ware, 1815, Wedgwood Museum, Barlaston.

Figure 22: G. Stubbs, *Wedgwood Family* (details).

Figure 23: J. Wedgwood, *Elizabeth Montagu*, 1775, jasper relief medallion, 41 x 33 x 10mm.

Figure 24: G. Stubbs, *Josiah Wedgwood*, 1780, oil on ceramic, 505 x 395mm.

Figure 25: M. Dahl, *Queen Anne*, 1705, oil on canvas, 2368 x 1448mm.

Figure 26: A. Ramsay (studio), *King George III,* 1761-2, oil on canvas, 1473mm x 1067mm.

Figure 27: W. Beechey, *King George III*, 1799-1800, oil on canvas, 2337mm x 1448mm.

Figure 28: F. Bartolozzi, after W. Hamilton, *On the General Illumination of his Majesty's Recovery,* 1790, mezzotint, 468 x 530mm.

Figure 29: Anon., *The Triumph of Hygeia,* 1789, mezzotint, 365 x 238mm.

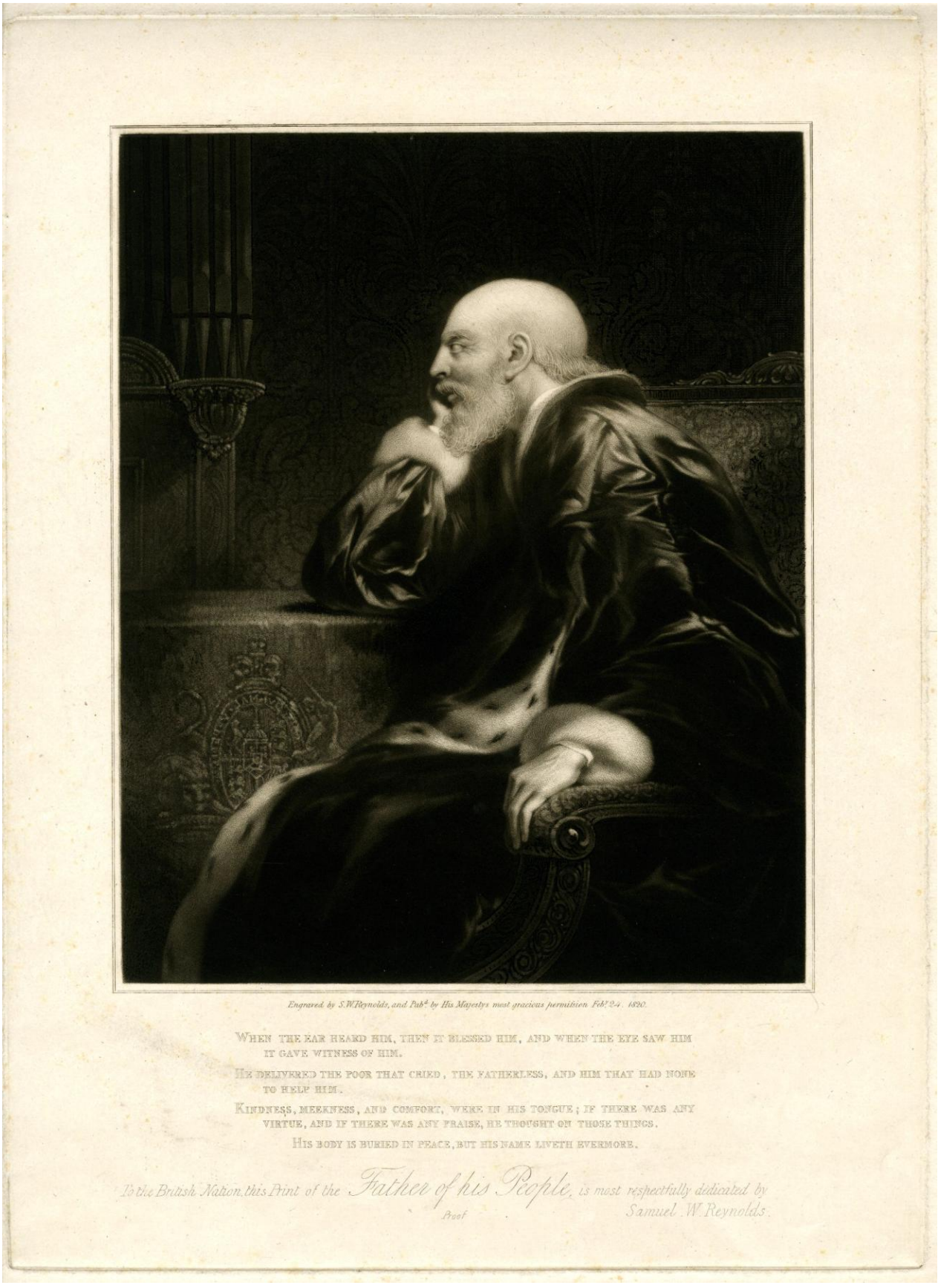


Figure 30: S. W. Reynolds, *George III,* 1820, mezzotint, 405 x 295mm.

Figure 31: S. W. Reynolds, *George III* (proof), 1820, mezzotint, 280 x 223mm.

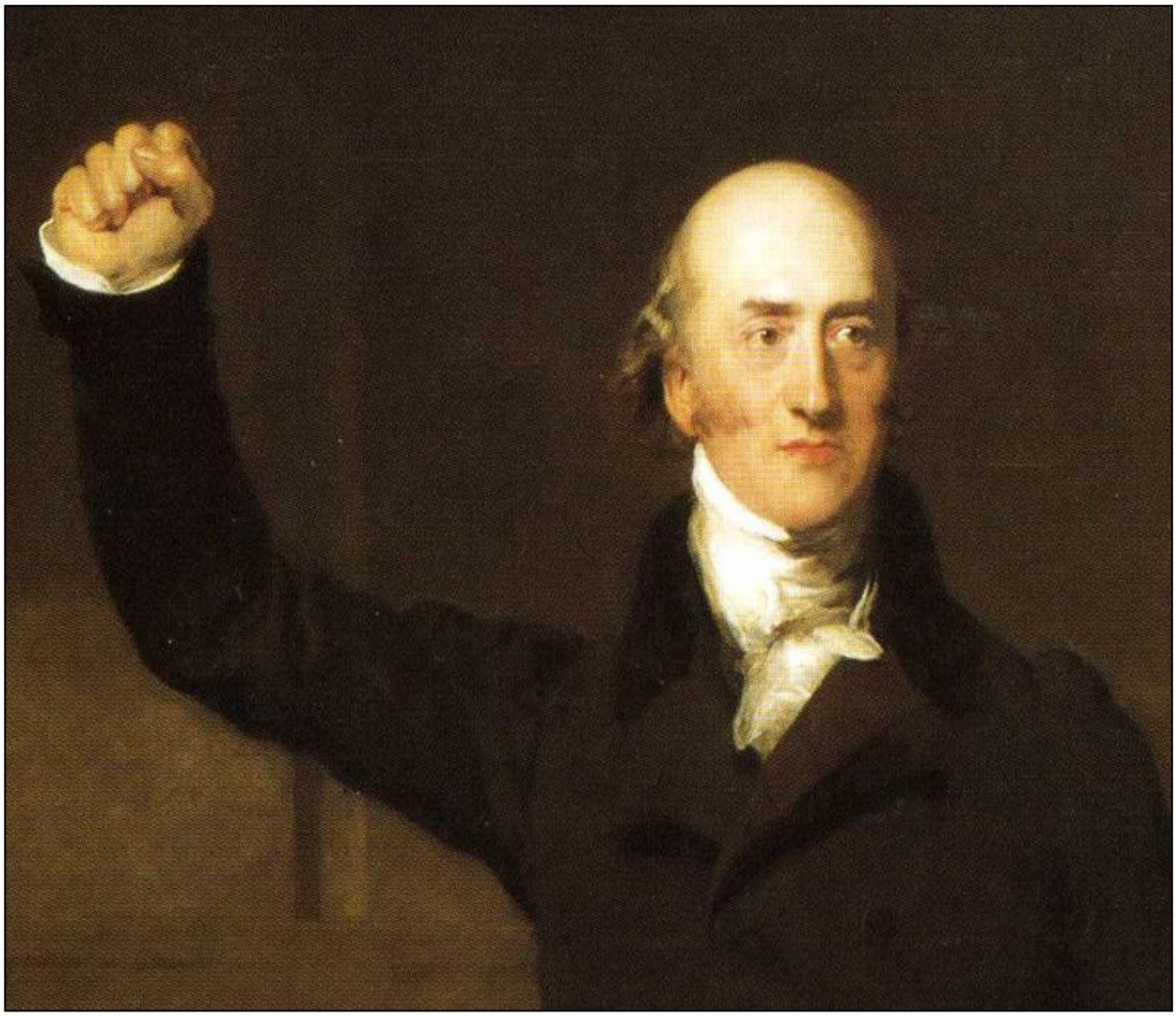


Figure 32: T. Lawrence, *George Canning* (detail), 1826, oil on canvas, 2385 x 1472mm.

Figure 33: T. Phillips, *Sir Francis Leggatt Chantrey,* 1818, oil on panel, 914 x 772mm.

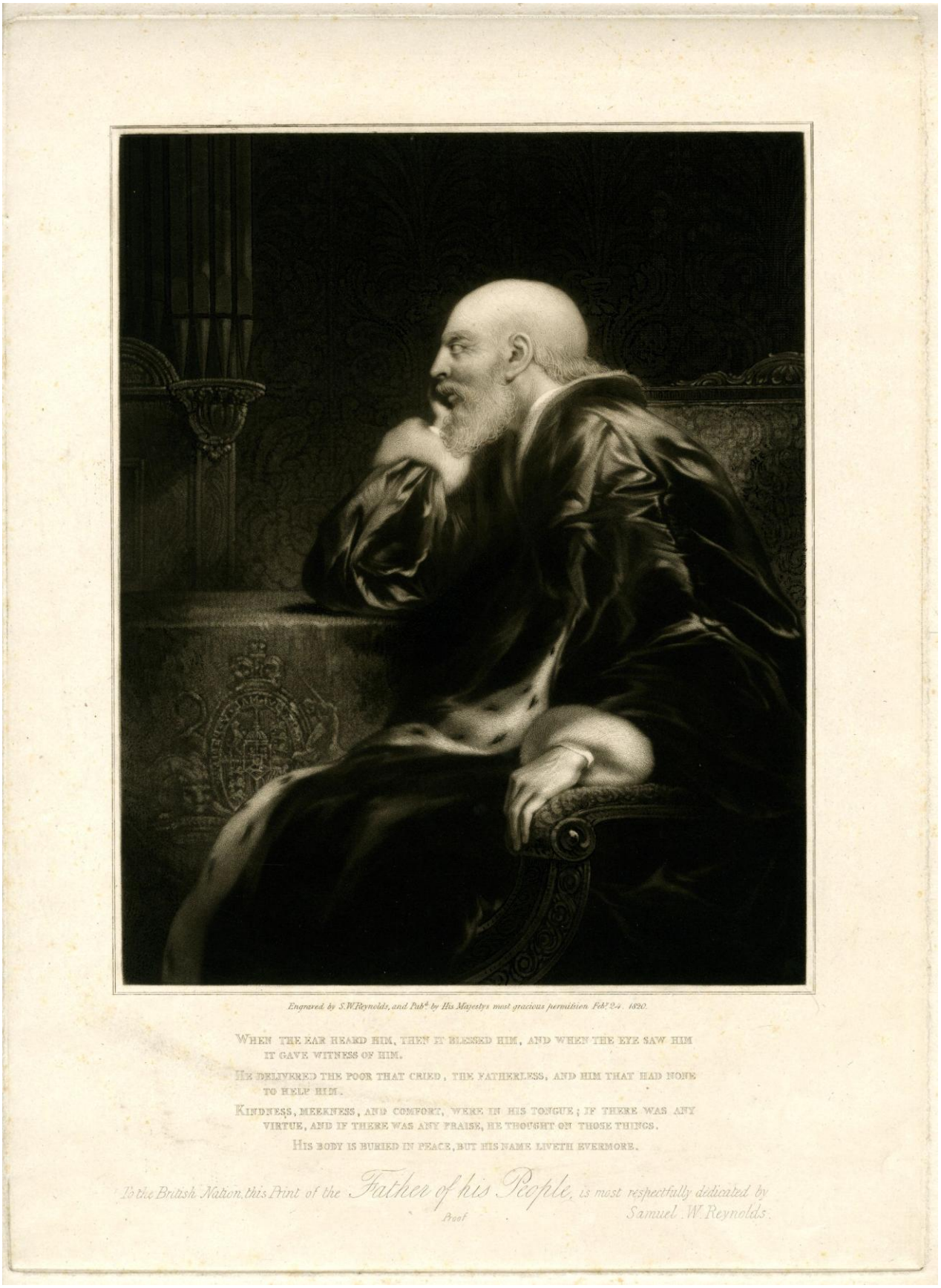


Figure 34: S. W. Reynolds, *George III,* 1820, mezzotint, 405 x 295mm.

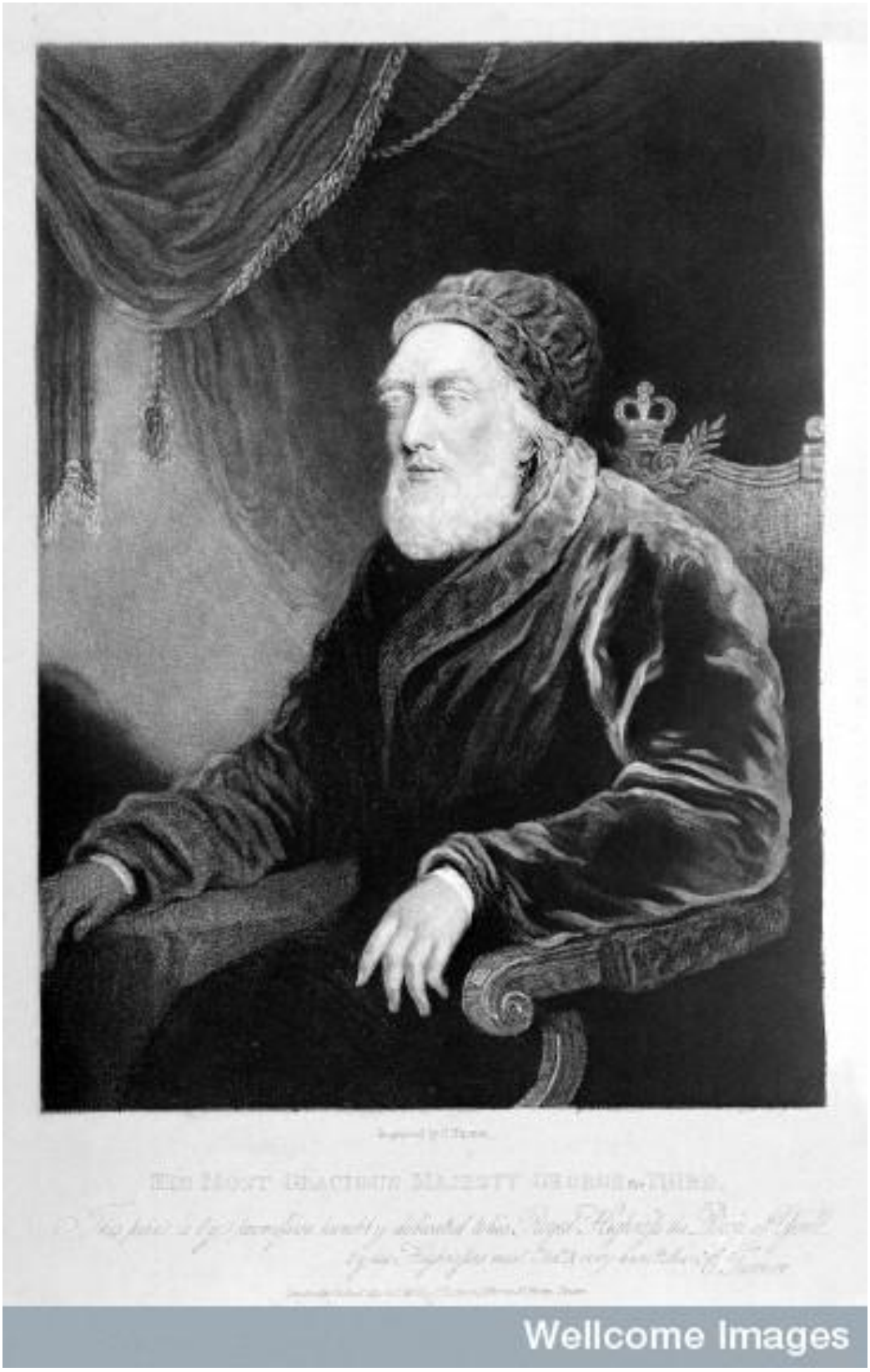


Figure 35: C. Turner, *King George the Third When Blind,* 1820, mezzotint/stipple/etching, 365 x 253mm.

Figure 36: A. Ramsay, *Study of hands for the portraits of George III (as Prince of Wales)...,* 1757, red chalk on paper, 310 x 230mm.

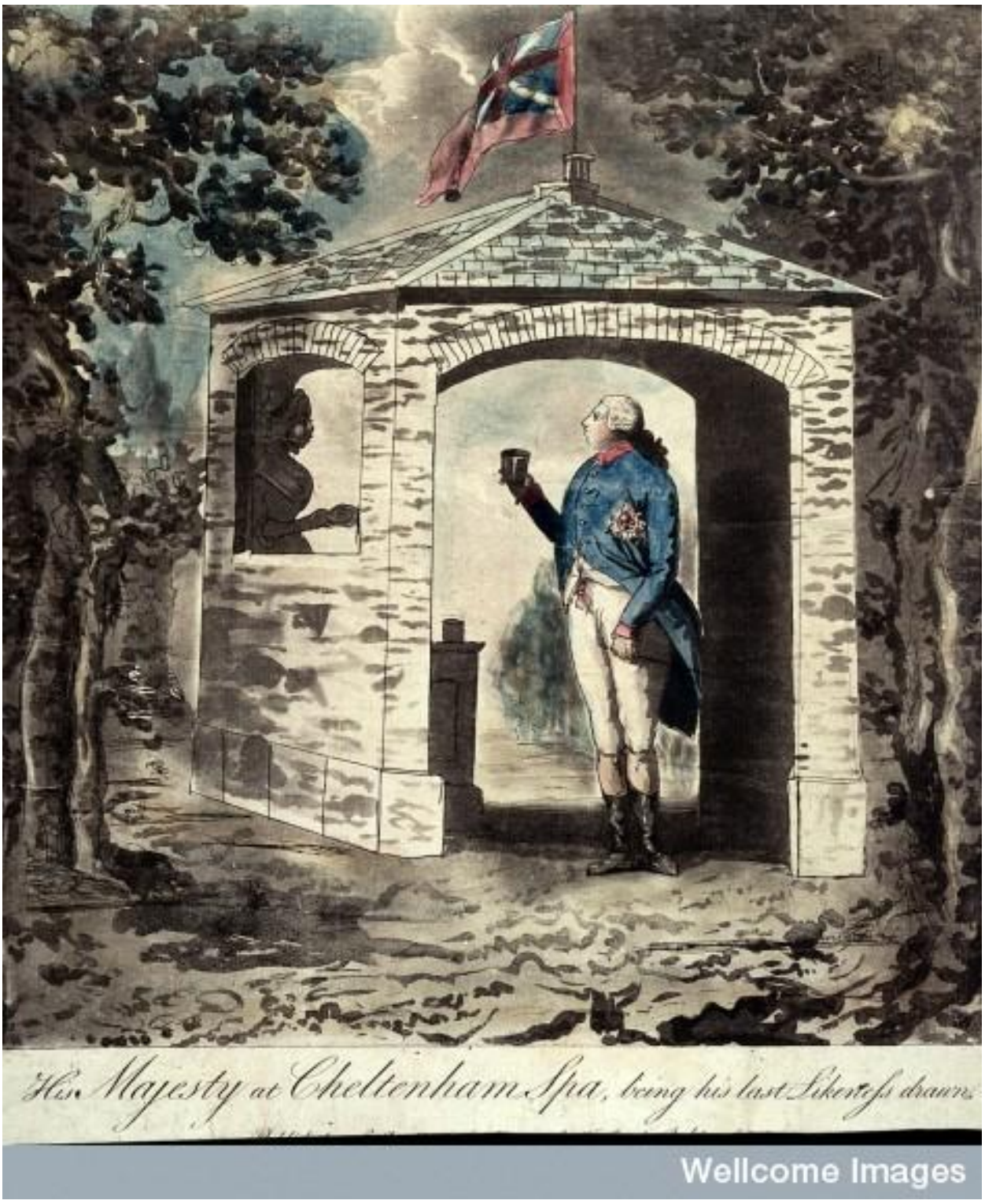


Figure 37: J. C. Stadler, *His Majesty at Cheltenham Spa,* 1819, aquatint with watercolour, 282 x 246mm.

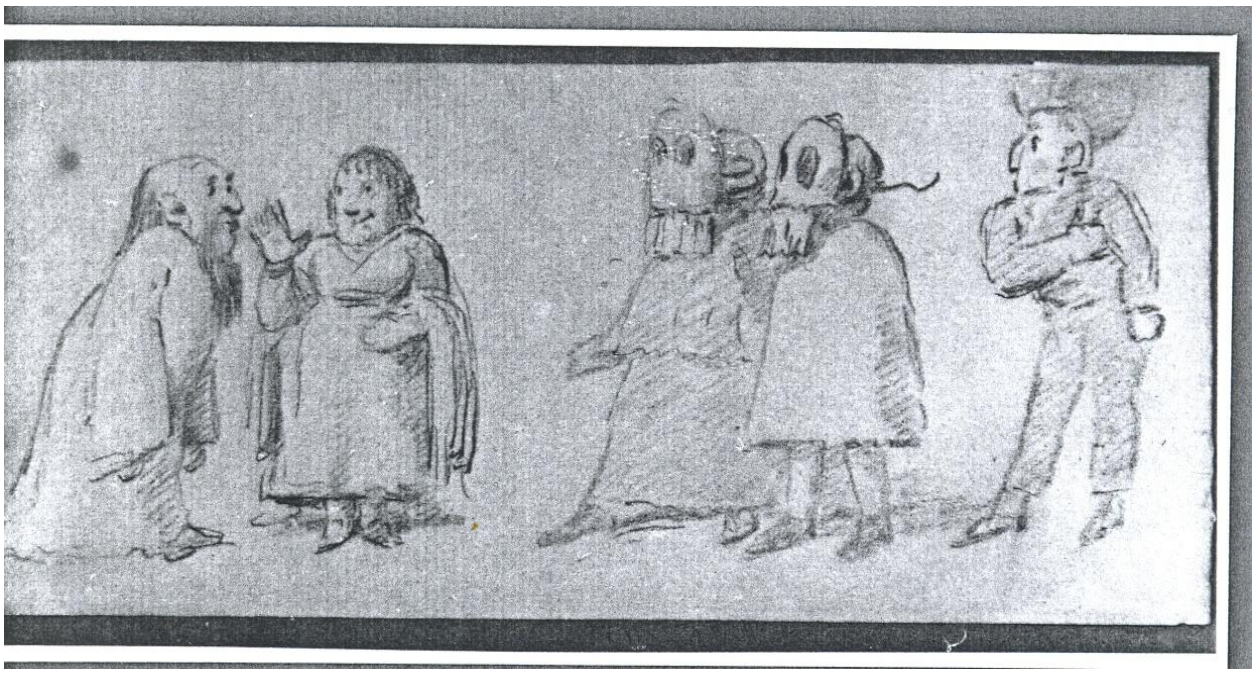


Figure 38: G. Dance, *Untitled*, n.d., pencil on paper, 241 x 826mm.

Figure 39: S. Ireland, after W. Hogarth, *Characters who frequented Button's Coffee-house about the year 1730*, 1786, etching, 163 x 202mm.

Figure 40: J. Bretherton, after C. L. Smith*, A Sunday Concert*, 1782, etching and aquatint, 357 x 491mm.

Figure 41: F. Bartolozzi (after), *Monument to Thomas Guy*, 1779, line engraving, 419 x 274mm.

Figure 42: A. Ramsay, *William Hunter,* c. 1764-5, oil on canvas, 960 x 750mm.

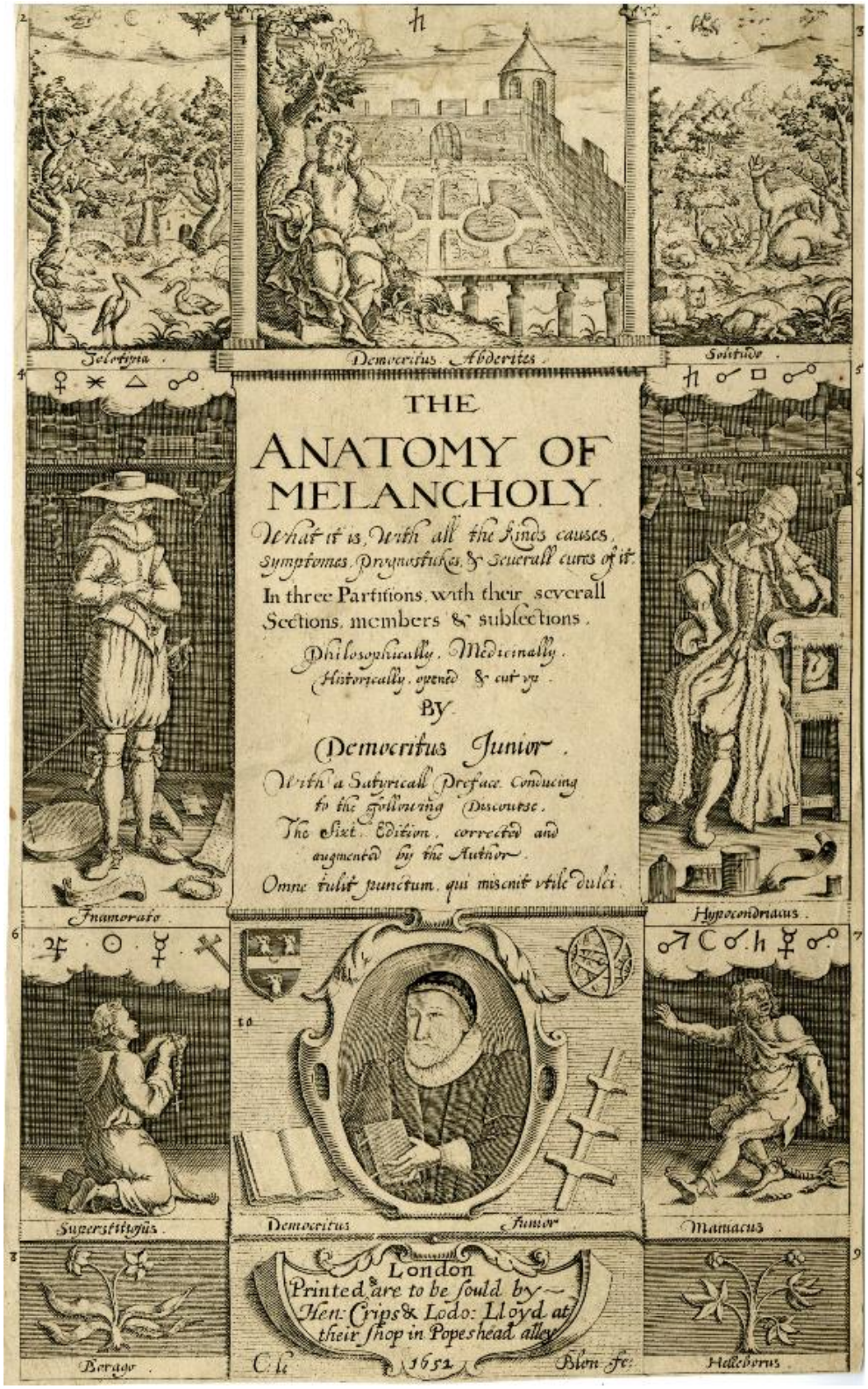


Figure 43: Frontispiece to R. Burton, *The Anatomy of Melancholy* (London, 1652).

Figure 44: G. White, after G. Kneller, *Mr Pope*, n.d., mezzotint, 201 x 150mm.

Figure 45: J. Houbraken, after A. Pond, *Alexander Pope*, 1747, line engraving, 350 x 216mm.

Figure 46: J. Reynolds, *Horace Walpole*, 1756-7, oil on canvas, 1272 x 1018mm.

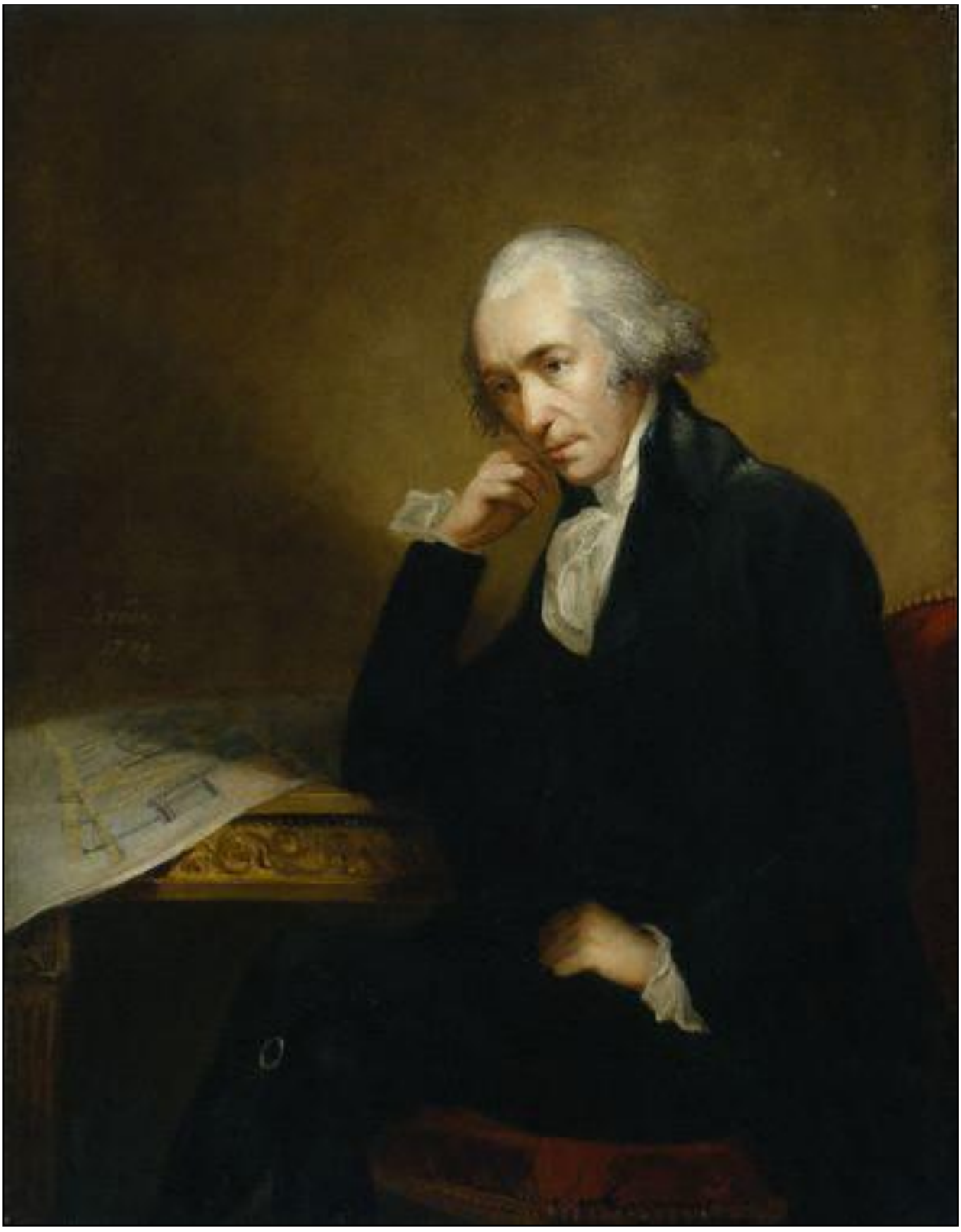


Figure 47: C. F. von Breda, *James Watt*, 1792, oil on canvas 1257 x 1003mm.

Figure 48: J. Reynolds, *Lawrence Sterne*, 1760, oil on canvas, 1273 x 1003mm.

Figure 49: C. Bowles, after J. Russell, *Selina Hastings, Countess of Huntingdon*, 1773, mezzotint, 502 x 353mm.

Figure 50: Anon., *Selina Hastings, Countess of Huntingdon*, n.d. (c. 1780s), oil on card, 565 x 438mm.

Figure 51: J. Fittler, after R. Bowyer, *Selina Hastings, Dowager of Huntingdon*, 1790, line engraving, 255 x 197mm (plate).

Figure 52: G. (Lord) Townshend, *The Boot & the Block-Head*, 1762, etching, 287 x 198mm.

Figure 53: C. Williams, *Iohn Bull contemplating a statue of Portland stone*, 1807, etching, 253 x 360mm.

Figure 54: J. Zoffany, *John and Mary Wilkes*, 1782, oil on canvas, 1264 x 1003mm.

Figure 55: Anon., *Francis Trouille: The Horned Man*, 1814, etching, 180 x 120mm.

Figure 56: Anon., *Francis Trovillou: The Horned Man*, n.d., stipple, 153 x 97mm.

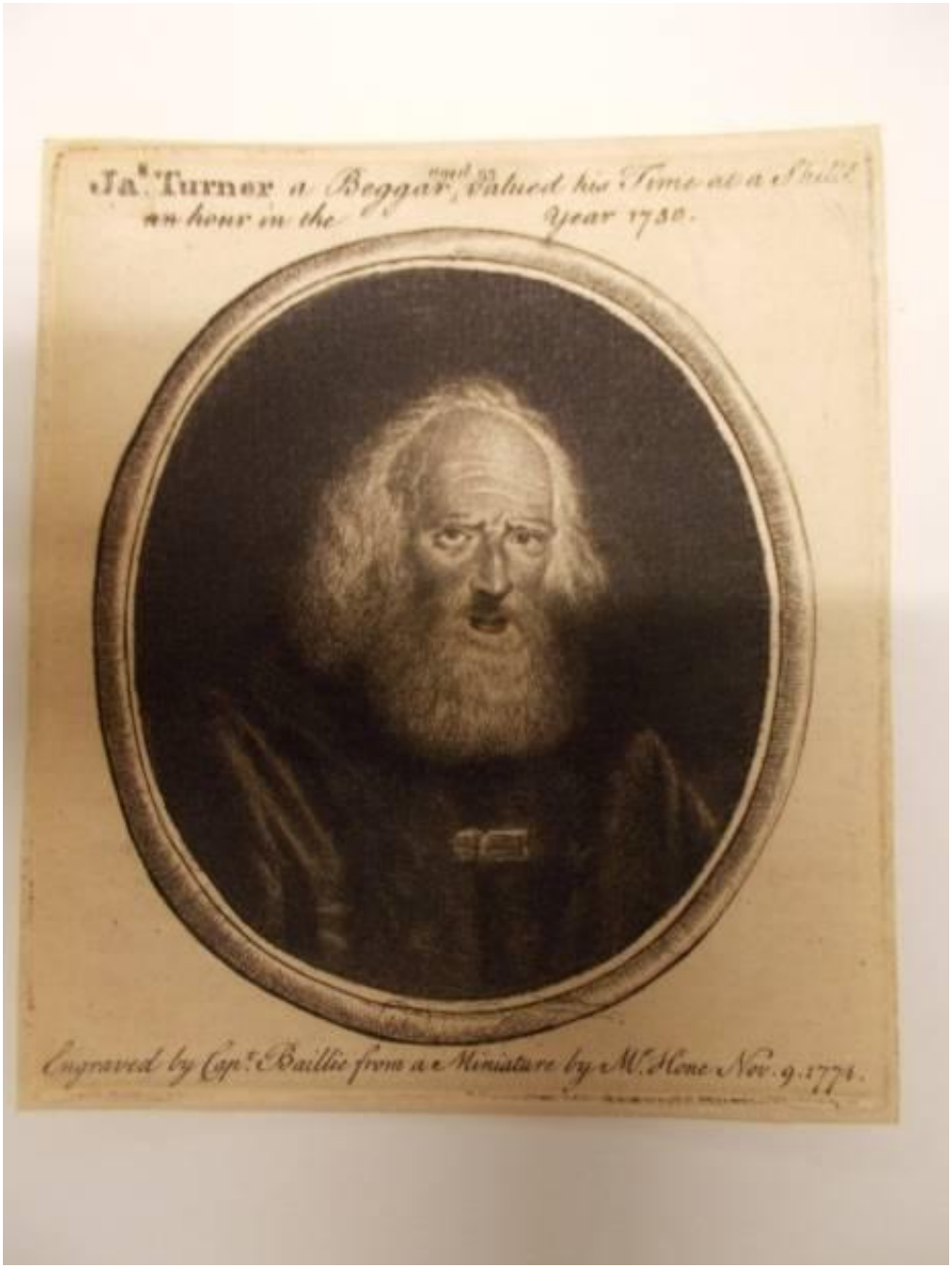


Figure 57: W. Baillie after N. Hone, *Jas Turner a Beggar...*, 1774, etching, 81 x 70mm (plate).

Figure 58: N. Edelink, *Charles de Saint Evremond*, line engraving, c. 1700, 194 x 149mm.

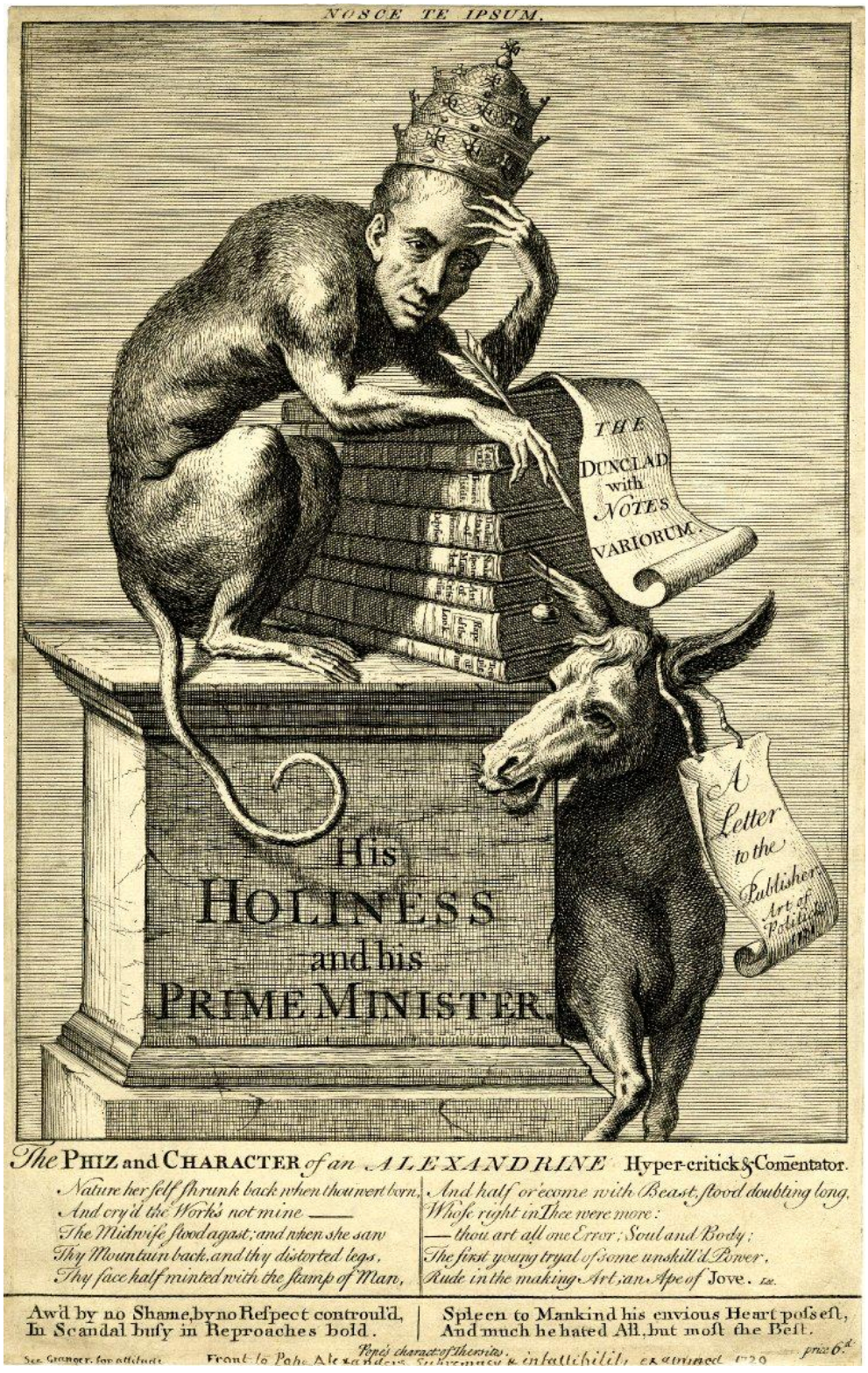


Figure 59: G. Duckett, *His Holiness and his Prime Minister*, 1729, etching, 337mm x 210mm.

Figure 60: Frontispiece to *Ingratitude; to Mr Pope..., (*London, 1733); separate etching on paper, c. 1733, 99mm x 75mm.

Figure 61: J. Richardson, *Mr Pope*, 1738, etching, 147 x 114mm.

Figure 62: J. Stow, after A. Pond, *Alex. Pope*, 1794, stipple and etching, 313 x 211mm.

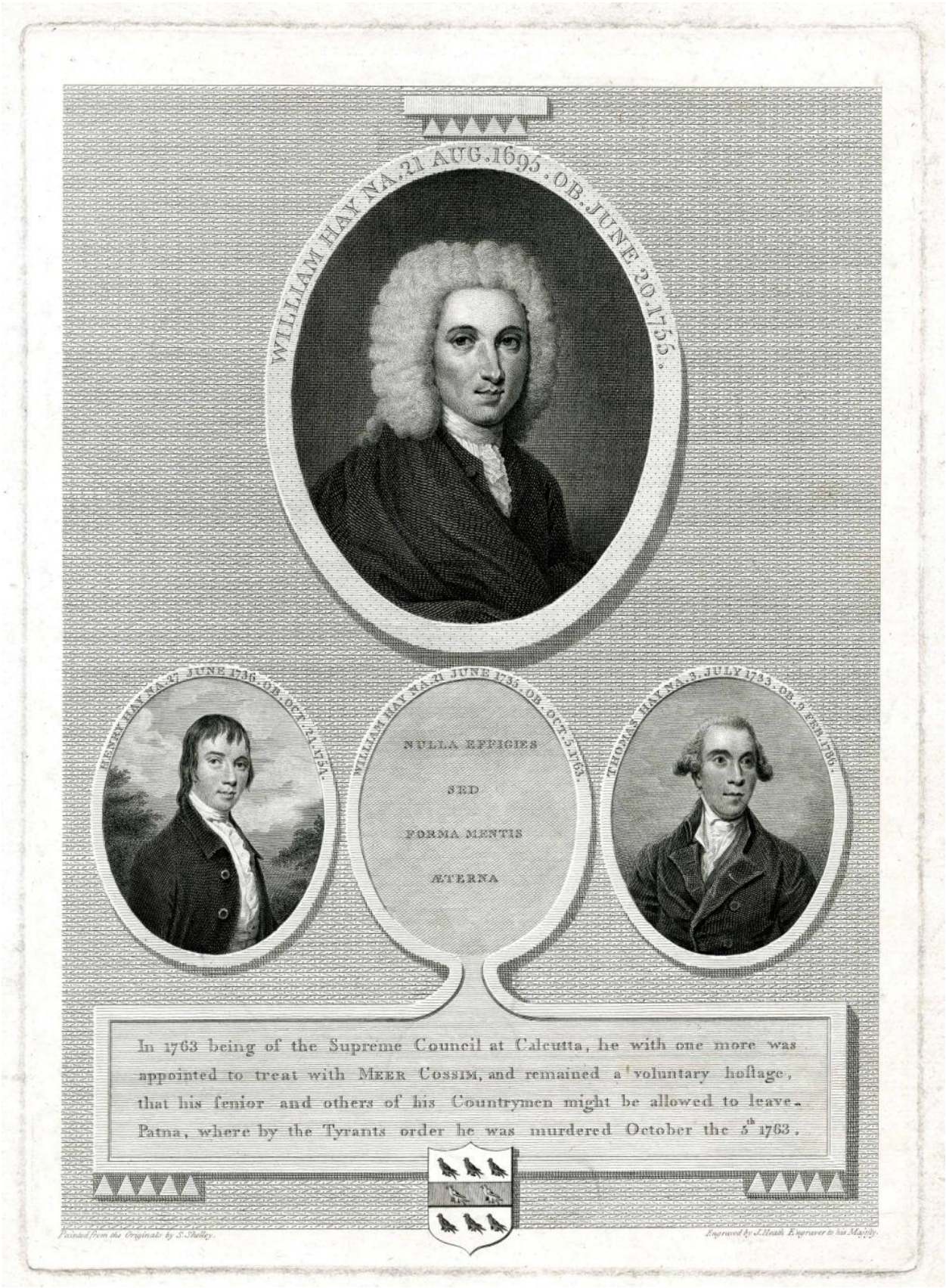


Figure 63: Frontispiece to *The Works of William Hay, Esq*.... (London, 1794).

Figure 64: J. Reynolds (attrib.), *William Hay*, n.d., oil on canvas, 743 x 616mm; and detail.

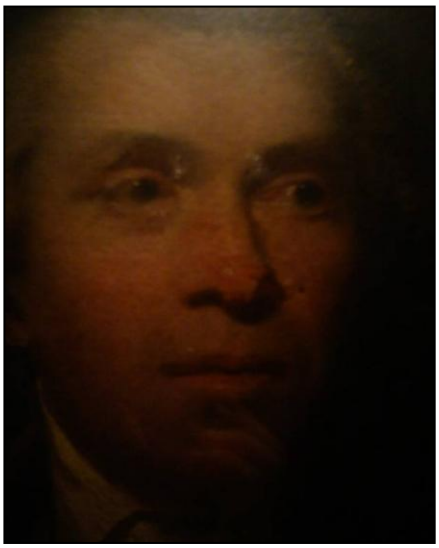
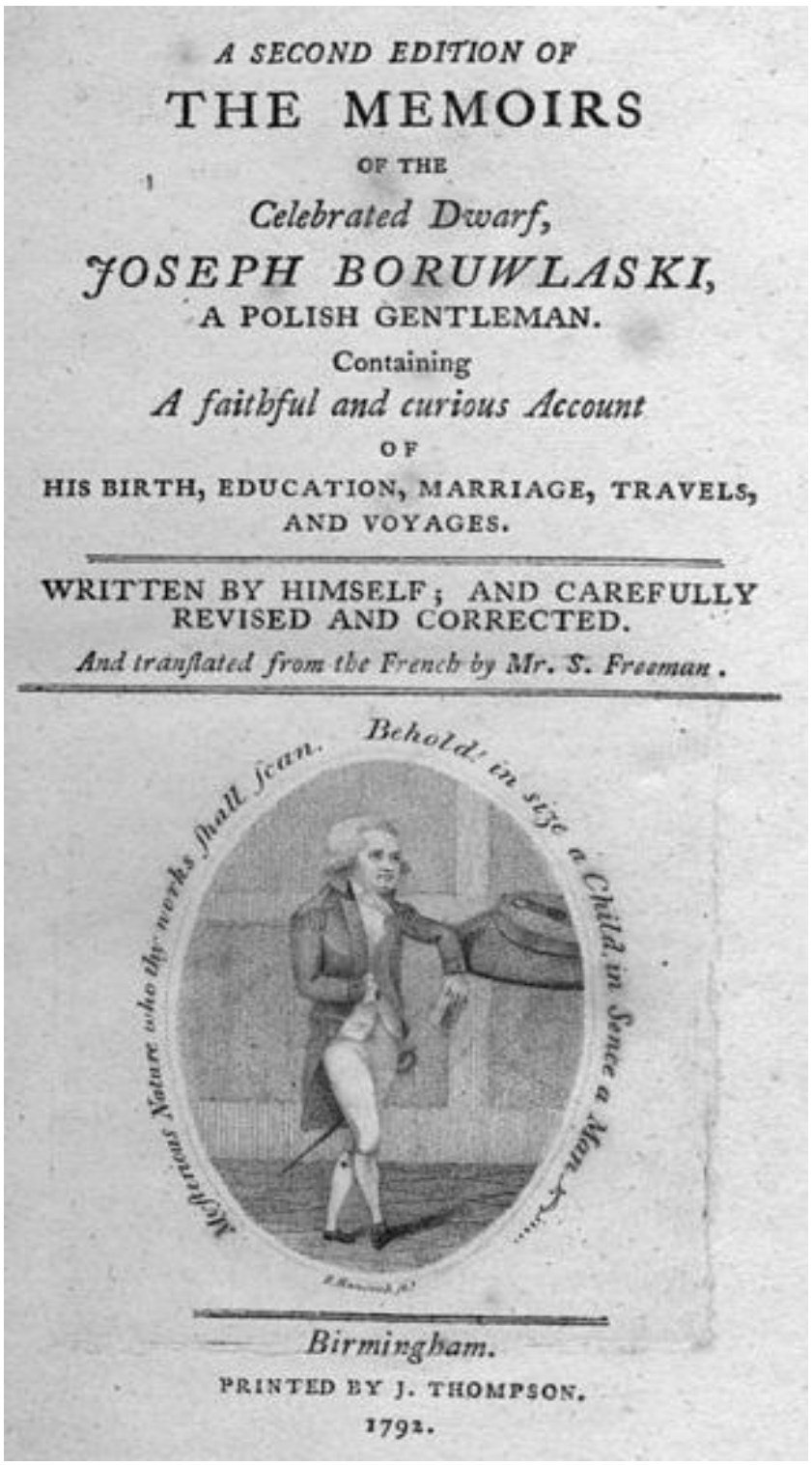


Figure 65: J. Kay, *Untitled*, 1802, etching; in Paterson, *A Series of Original Portraits and Caricature Etchings* (Edinburgh, 2 vols., 1878), i, 329.

Figure 66: S. W. Fores (pub.), *The Natty, Lad or Polish, Dwarf taking an airing*, 1787, etching, 248 x 172mm.

Figure 67: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious account of his birth, education, marriage, travels and voyages; written by himself* (trans. Des Carrieres, London, 1788).

Figure 68: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious account of his birth, education, marriage, travels and voyages; written by himself* (trans. Des Carrieres, London, 1788).


A SECOND EDITION OF

THE MEMOIRS

OF THE

Celebrated Dwarf,

JOSEPH BORUWLASKI,

A POLISH GENTLEMAN.

Containing

A faithful and curious Account

OF

HIS BIRTH, EDUCATION, MARRIAGE, TRAVELS, AND VOYAGES.

WRITTEN BY HIMSELF; AND CAREFULLY REVISED AND CORRECTED.

And tranſlated from the French by Mr. S. Freeman.

Behold! in size a Child, in Sence a Man,
Whom various Nature who thy works shall scan.

Birmingham.

PRINTED BY J. THOMPSON.

1792.

Figure 69: Frontispiece to J. Boruwlaski, *Memoirs of the celebrated dwarf, Joseph Boruwlaski, a Polish gentleman, containing a faithful and curious Account of his birth, education, marriage, travels and voyages; written by himself* , *and carefully revised and corrected* (trans. S. Freeman, Birmingham, 1795).

Figure 70: Frontispiece to J. Boruwlaski, *Memoirs of Count Boruwlaski* (Durham, 1820).

Figure 71: P. Reinagle, *Josef Boruwlaski*, n.d. oil on canvas, 1360 x 1080mm.

Figure 72: S. Percy, Josef Boruwlaski, 1798, wax amulet, 187 x 162mm.

Figure 73: J. Zoffany, *William Hunter Teaching Anatomy at the Royal Academy*, c. 1772, oil on canvas, 774 x 1035mm.

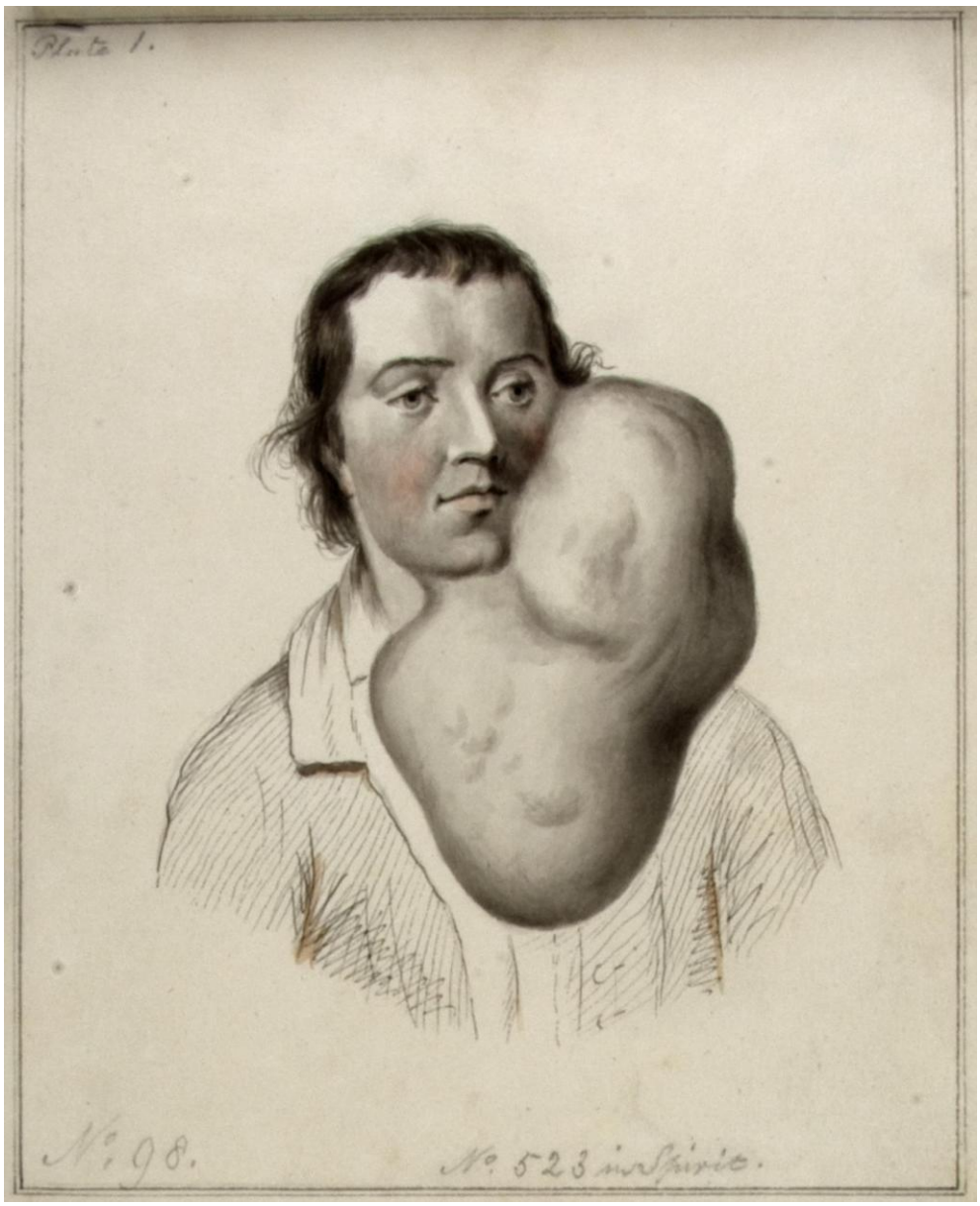


Figure 74: W. Bell, *John Burley*, 1785, ink and watercolour on paper, RCSEng, HDB/4/2/387/1.

Figure 75: W. Bell, *John Burley*, 1785, ink and watercolour on paper, RCSEng, HDB/4/2/387/2.

Figure 76: W. Bell, *Miss Miller*, 1781, graphite on paper, RCSEng, HDB/3/1/857/1.

Figure 77: J. Rymsdyk, *Jonathan Burn*, 1755, watercolour on paper, RCSEng, HDB/4/2/405/1.

Figure 78: J. Rymsdyk*, Jonathan Burn*, 1755, watercolour on paper, RCSEng, HDB/4/2/406/1.

Figure 79: J. Hunter, *Hydrocephalus* [of Jonathan Burn], 1755, graphite on paper, RCSEng, HDB/4/2/407/2.

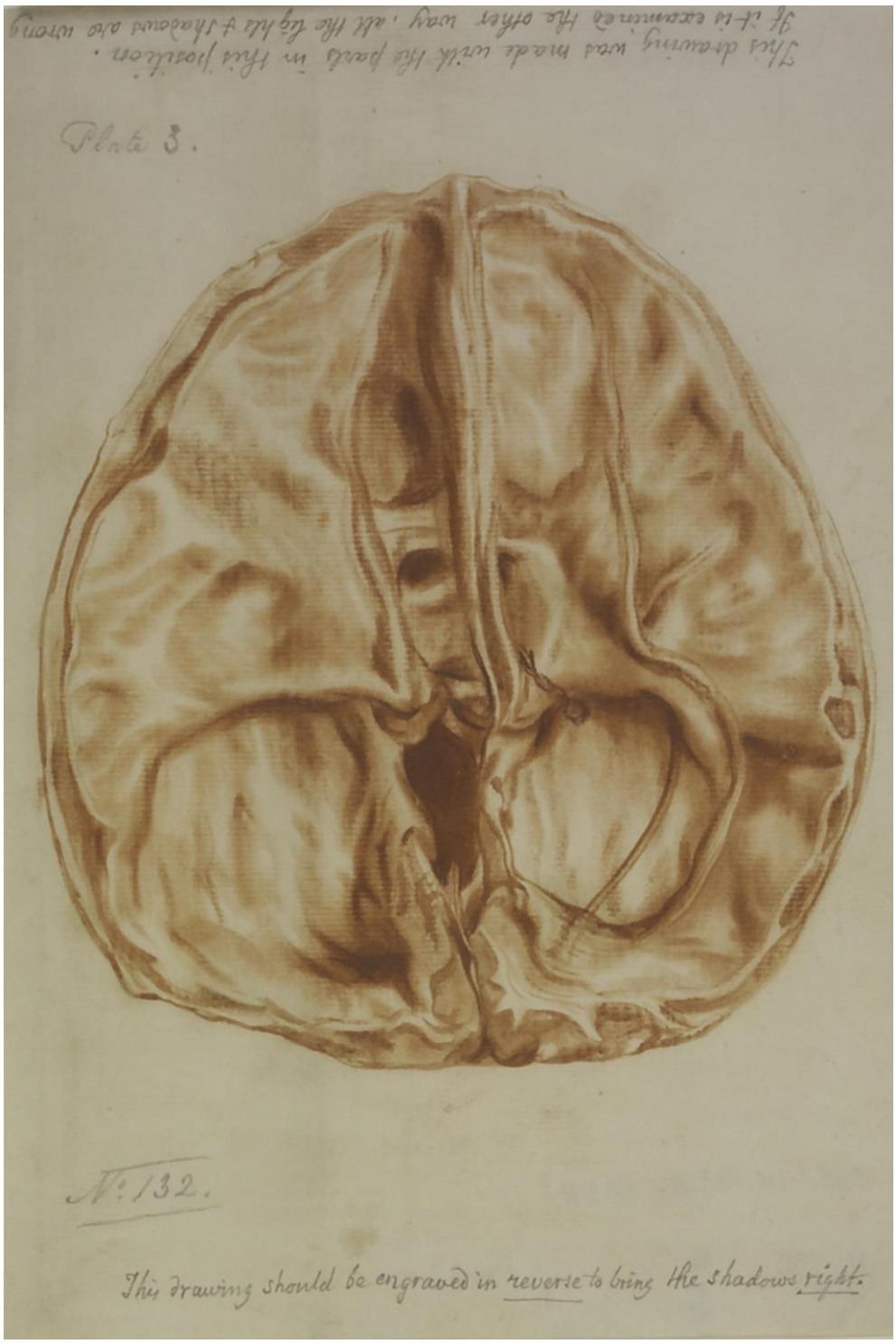


Figure 80: J. Rymsdyk, *Jonathan Burn*, 1755, graphite on paper and watercolour on paper, RCSEng, HDB/4/2/407/1.

Figure 81: W. Bell, *Thomas Norman*, 1785, graphite on paper, RCSEng, HDB/4/2/410/1.

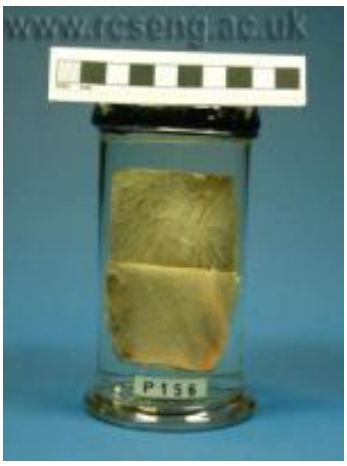


Figure 82: surviving preparation from Norman's case, RCSEng, RCSHC/P /154.

Figure 83: surviving preparation from Norman's case, RCSEng, RCSHC/P /155.

Figure 84: surviving preparation from Norman's case, RCSEng, RCSHC/P /156.

Figure85: surviving preparation from Norman's case, RCSEng, RCSHC/P /1186.

Figure 86: Bailey, after Beaumont, *No. 1*, n.d., ink and graphite on paper, RCSEng, HDB/3/1/843A/1.

Figure 87: Bailey, after Beaumont, *No. 2*, n.d., ink and graphite on paper, RCSEng, HDB/3/1/843A 2.

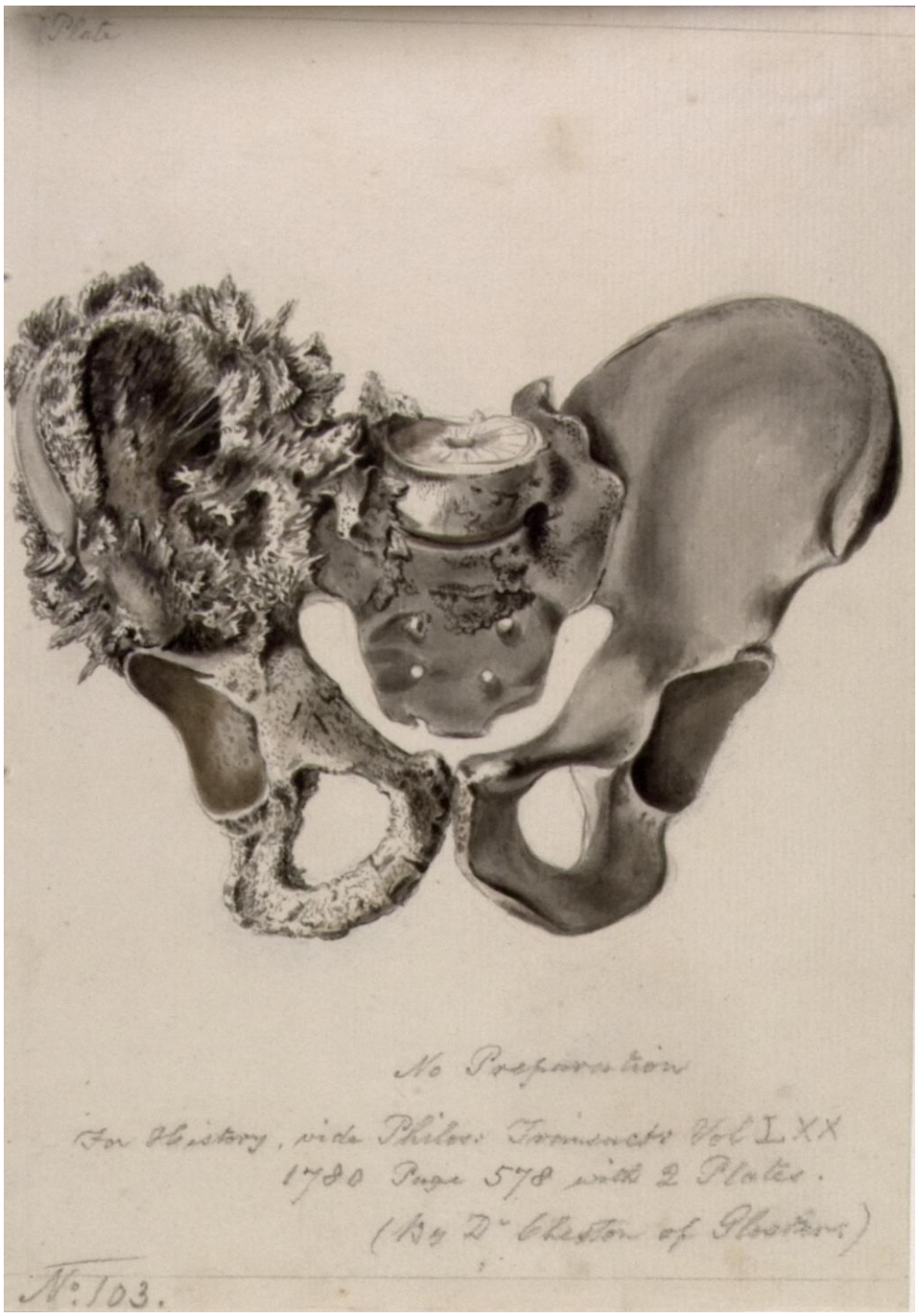


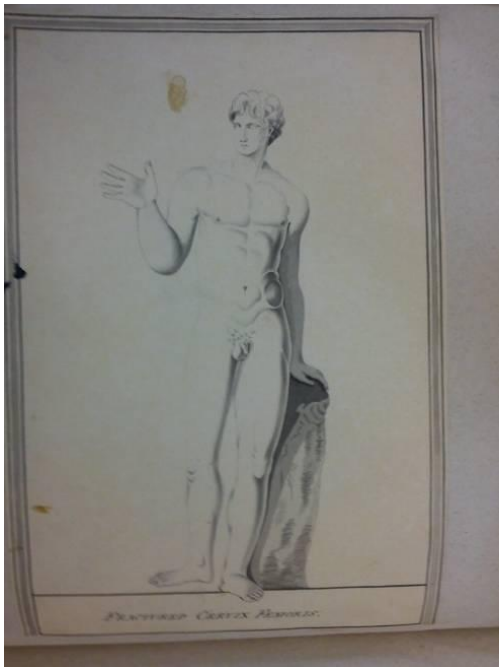
Figure 88: R. Cheston, *James Jones*, 1779, graphite on paper, RCSEng, HDB/4/2/390/1.

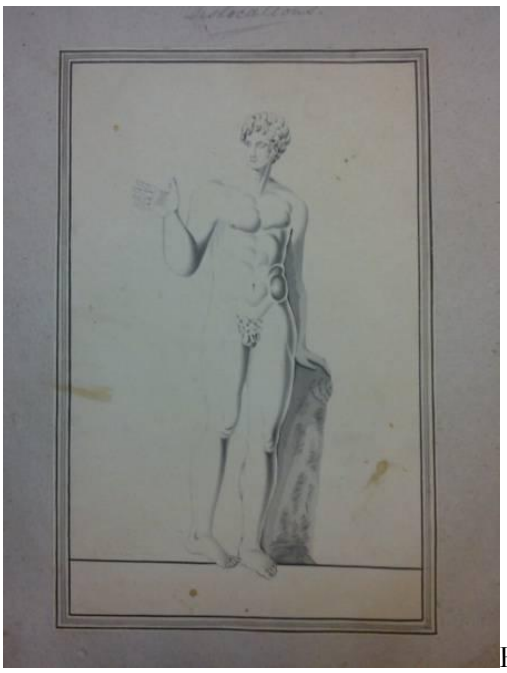
Figure 89: J. Basire after K.(?) Rickelts, *No. 1*, 1780, line engraving, in *Philosophical Transactions of the Royal Society*, 52, plate XIII.

Figure 90: T. Reichel, *Peruntaloo*, 1787, graphite and ink on paper, RCSEng, HDB/3/1/845/1.


Dislocation of the Pubis


Dislocation in the Foramen Ovale.


Posterior Cervix Humeri


Figures 91-95: RCSEng MS0008/4/5/5, ff. 794ff.

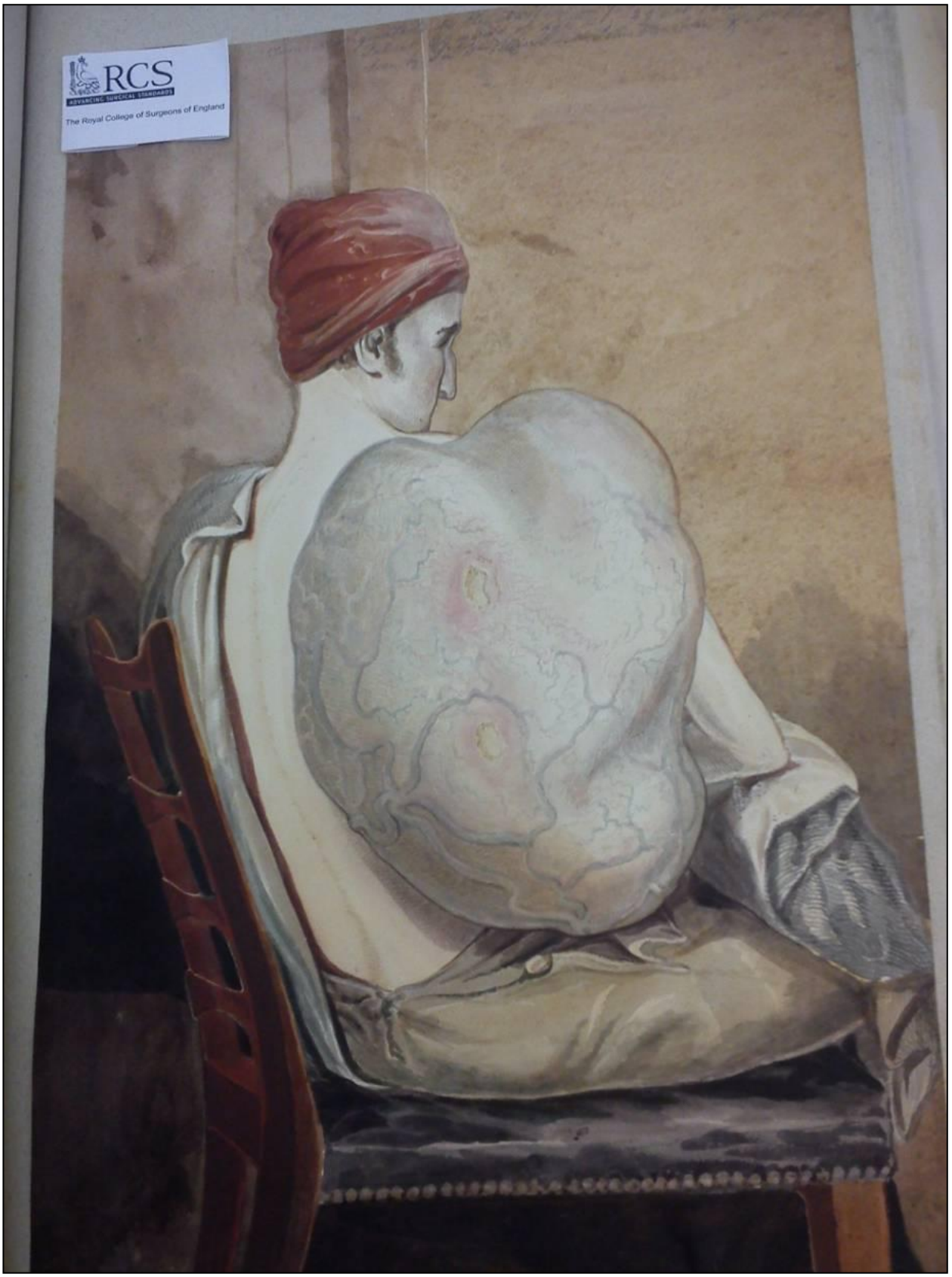


Figure 96: Anon., *John Adams*, n.d., watercolour and oil on paper, RCSEng MS0008/4/5/6, f. 319r.

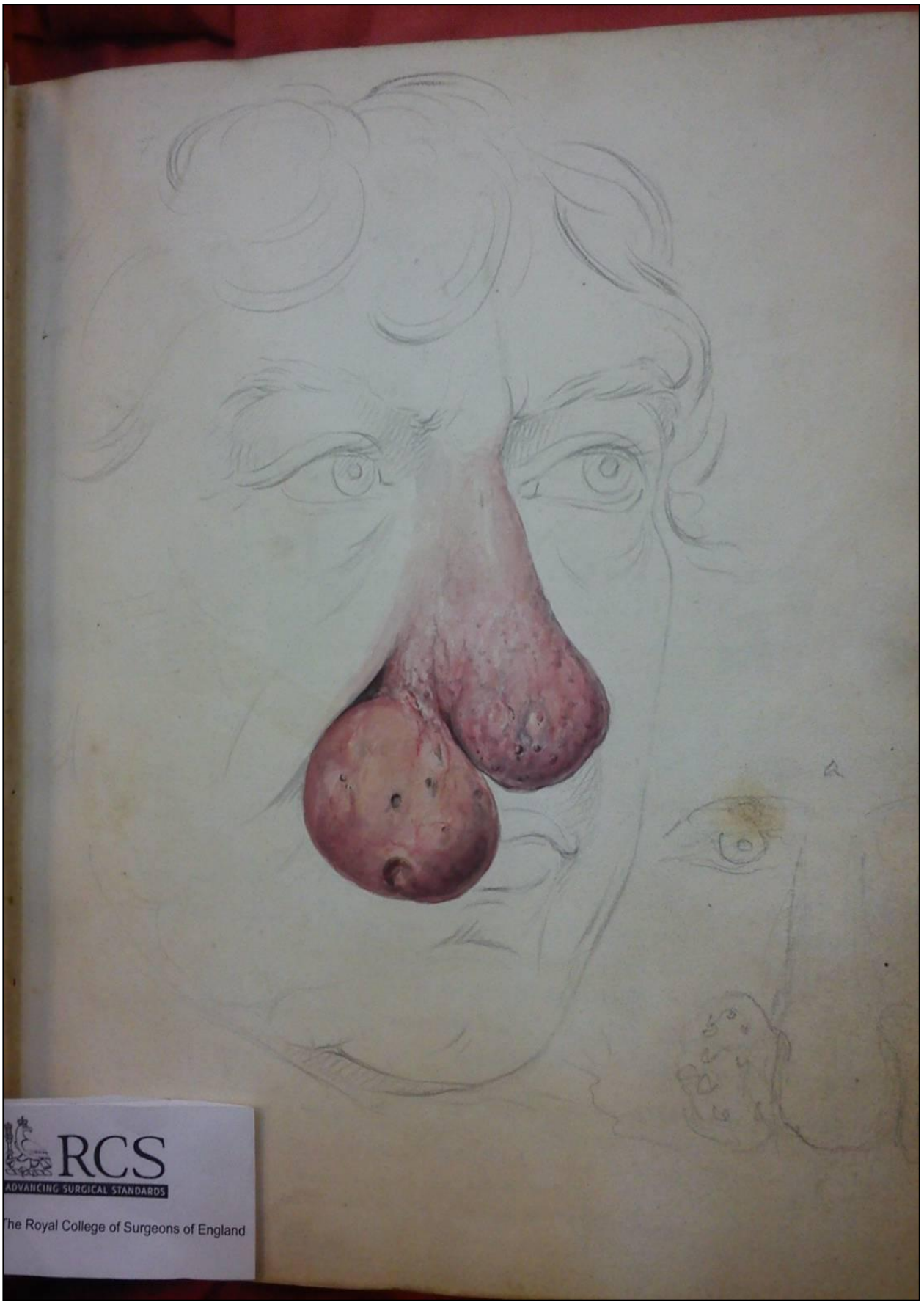


Figure 97: Anon., *Joseph Silvester Aet 73...,* n.d., graphite and watercolour on paper, RCSEng MS0008/4/4, f. 1.

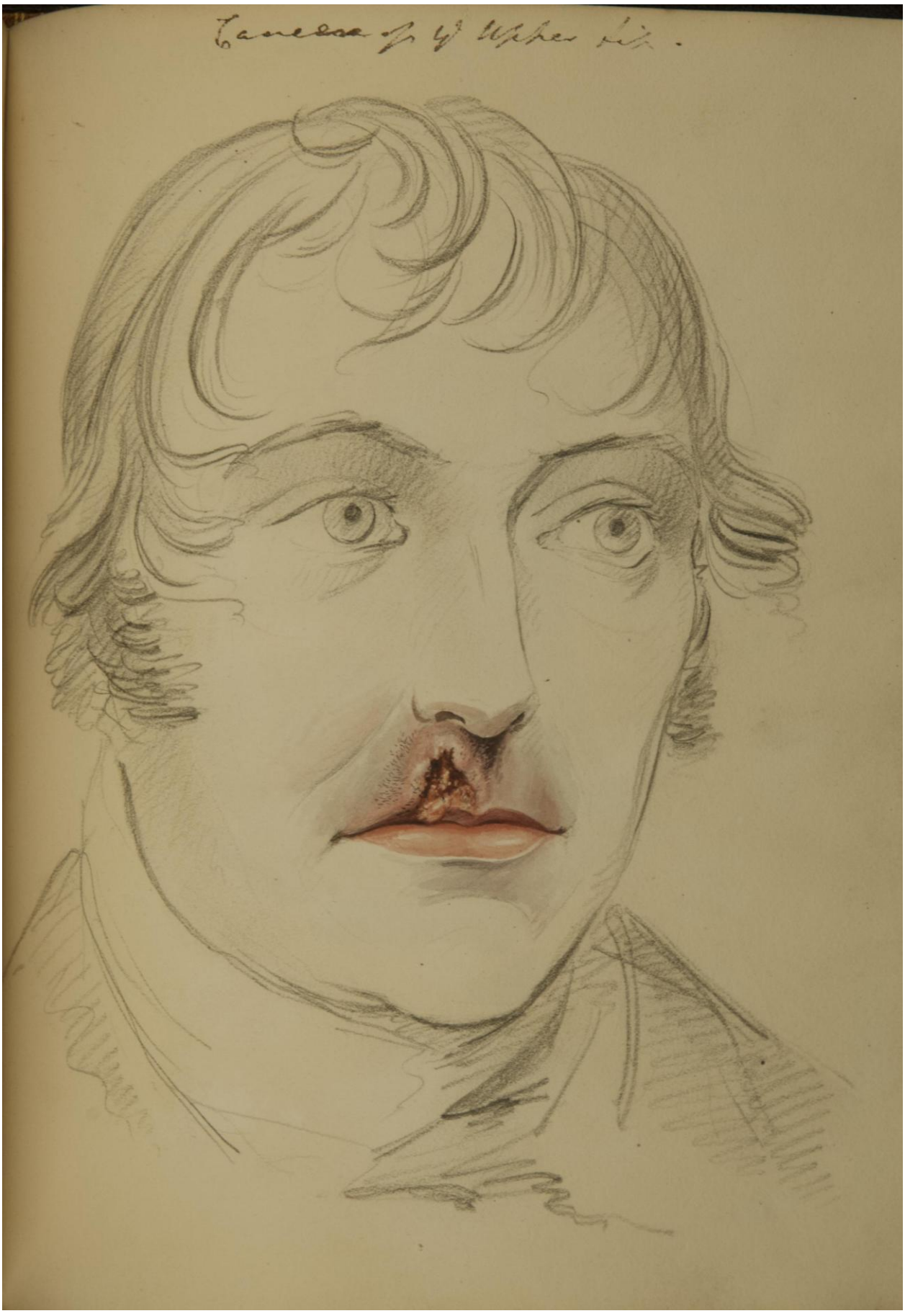


Figure 98: Anon., *Cancer of ye Upper Lip* [of Joseph Marner], n.d., graphite and watercolour

on paper, RCSEng MS0008/4/4, ff. 242-3.

Figure 99: Anon., *Andrew Griffin Aet 3*, RCSEng MS0008/4/4, ff. 40-1.

Figure 100: Anon., *Disease of ye Popliteal Nerve* [of Mrs Dodd(s?)], RCSEng MS008/4/5/3, f. 390r.

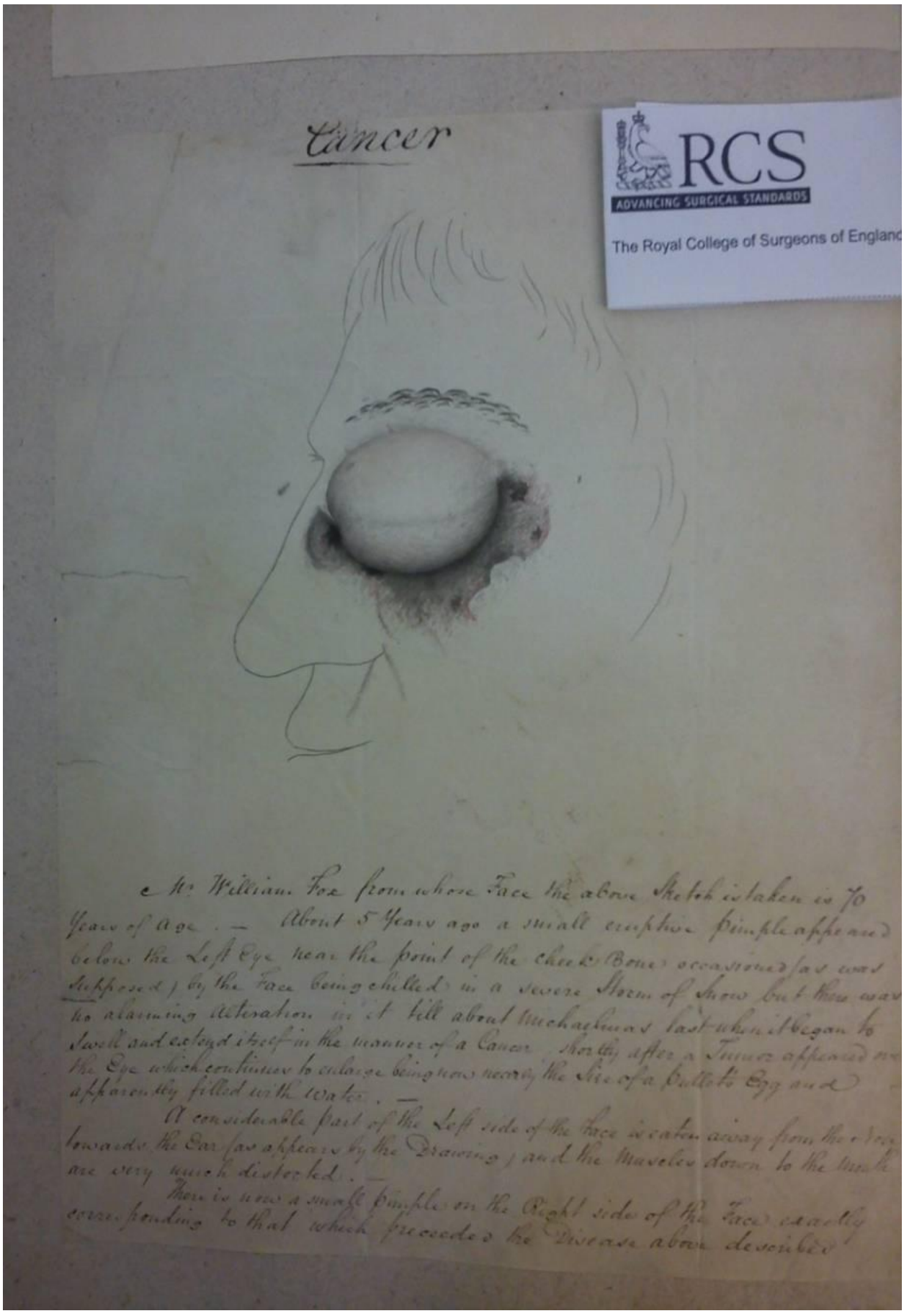


Figure 101: Anon., *Cancer* [of William Fox], RCSEng MS008/4/5/8, f. 505.

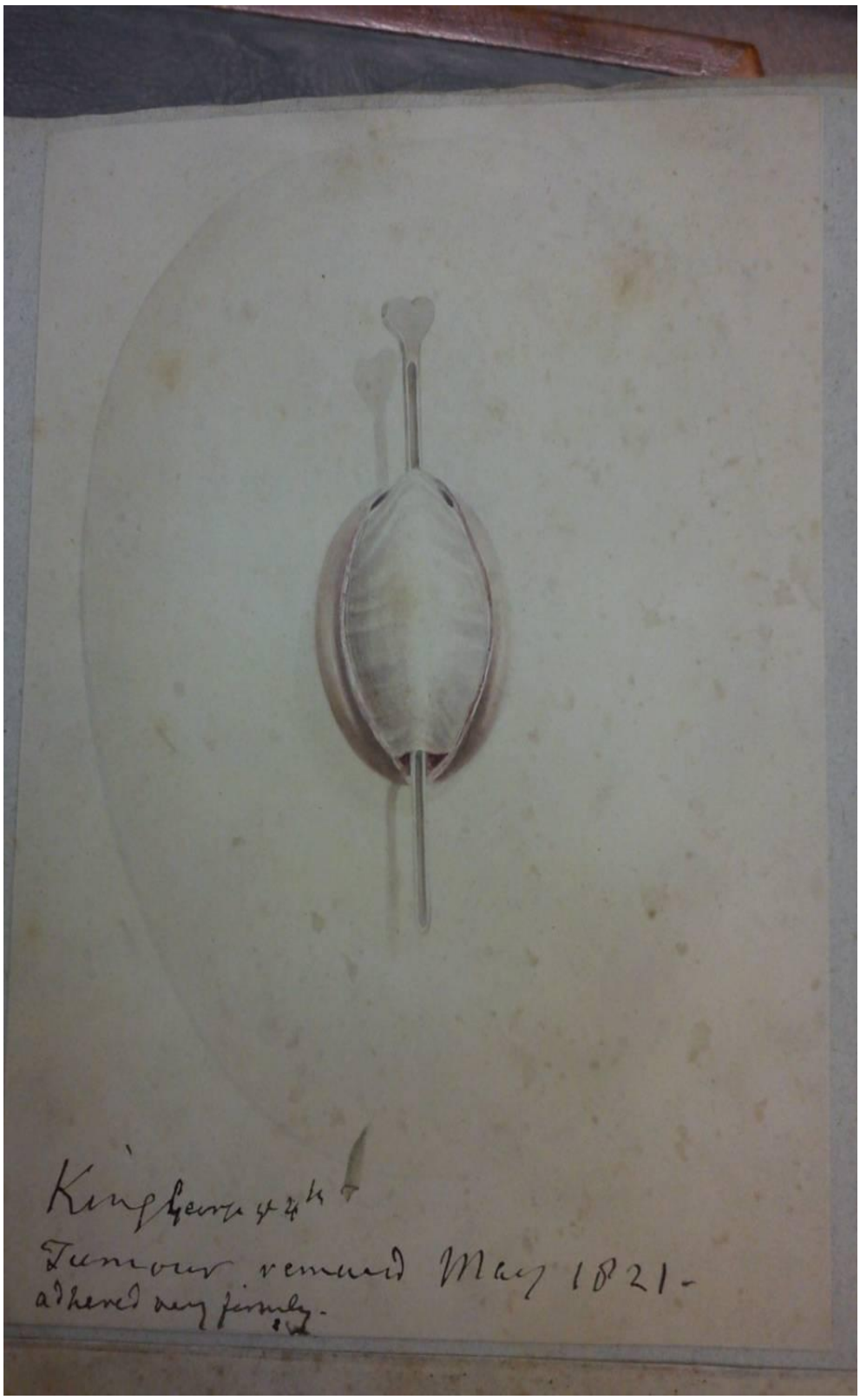


Figure 102: Anon., *Untitled*, RCSEng MS 0008/4/5/6, f. 317r.

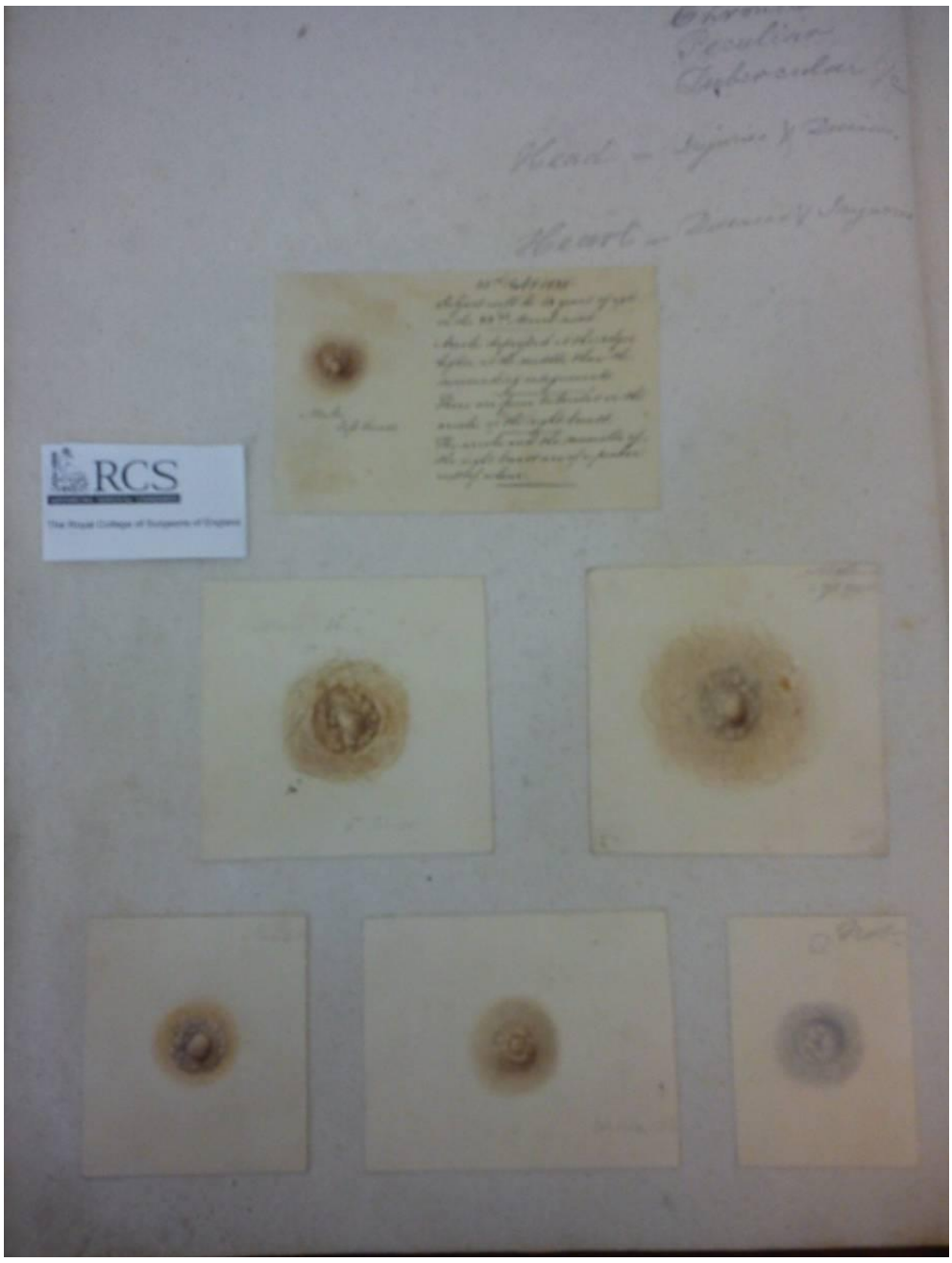


Figure 103: RCSEng MS0008/4/5/3, ff. 103ff.

Figure 104: J. Thomson, *François Chapuis,* 1815, pen and ink on paper, *Sketches,* f. 31.

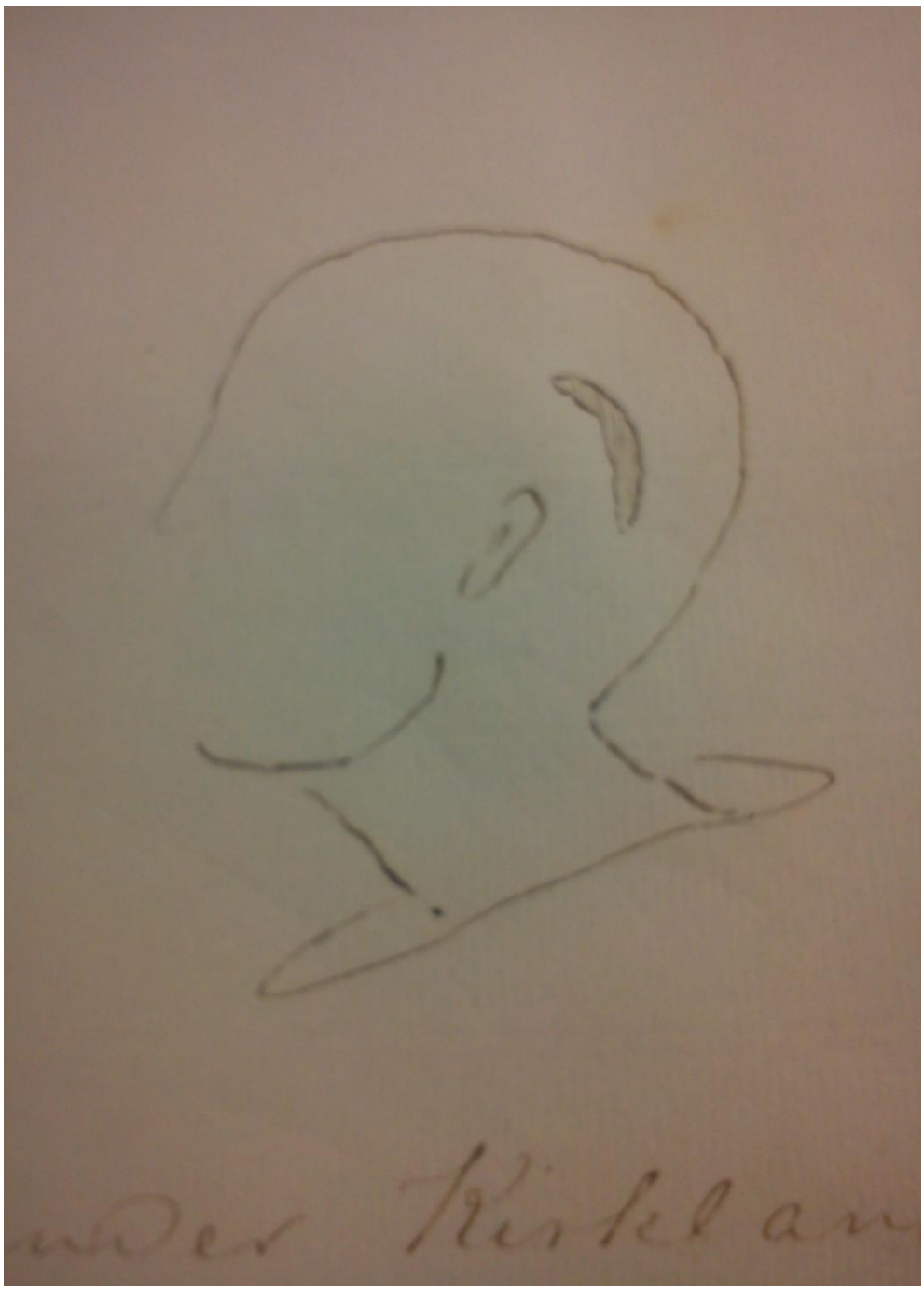


Figure 105: J. Thomson, *Alexander Kirkland,* 1815, pen and ink on paper, *Sketches* f. 26.

Figure 106: J. Thomson, *Joseph Holleran,* 1815, pen and ink on paper, *Sketches,* f. 31.

Figure 107: J. Thomson, *Sanges*, 1815, pen and ink on paper, *Sketches*, f. 56.

Figure 108: J. Thomson, *William Ryan*, 1815, pen and ink on paper, *Sketches*, f. 43.

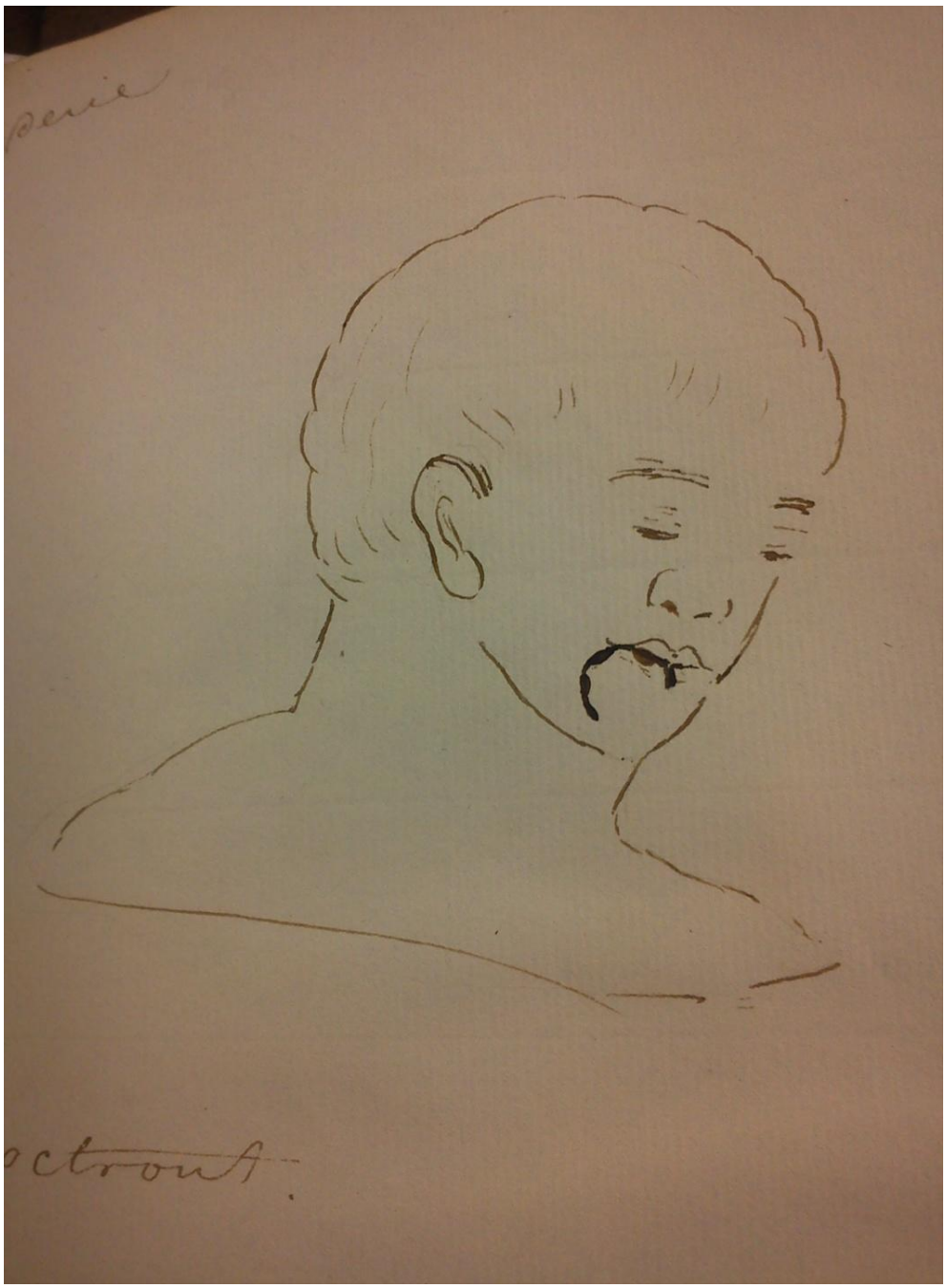


Figure 109: J. Thomson, *Froctront*; 1815, pen and ink on paper, *Sketches,* f. 37.

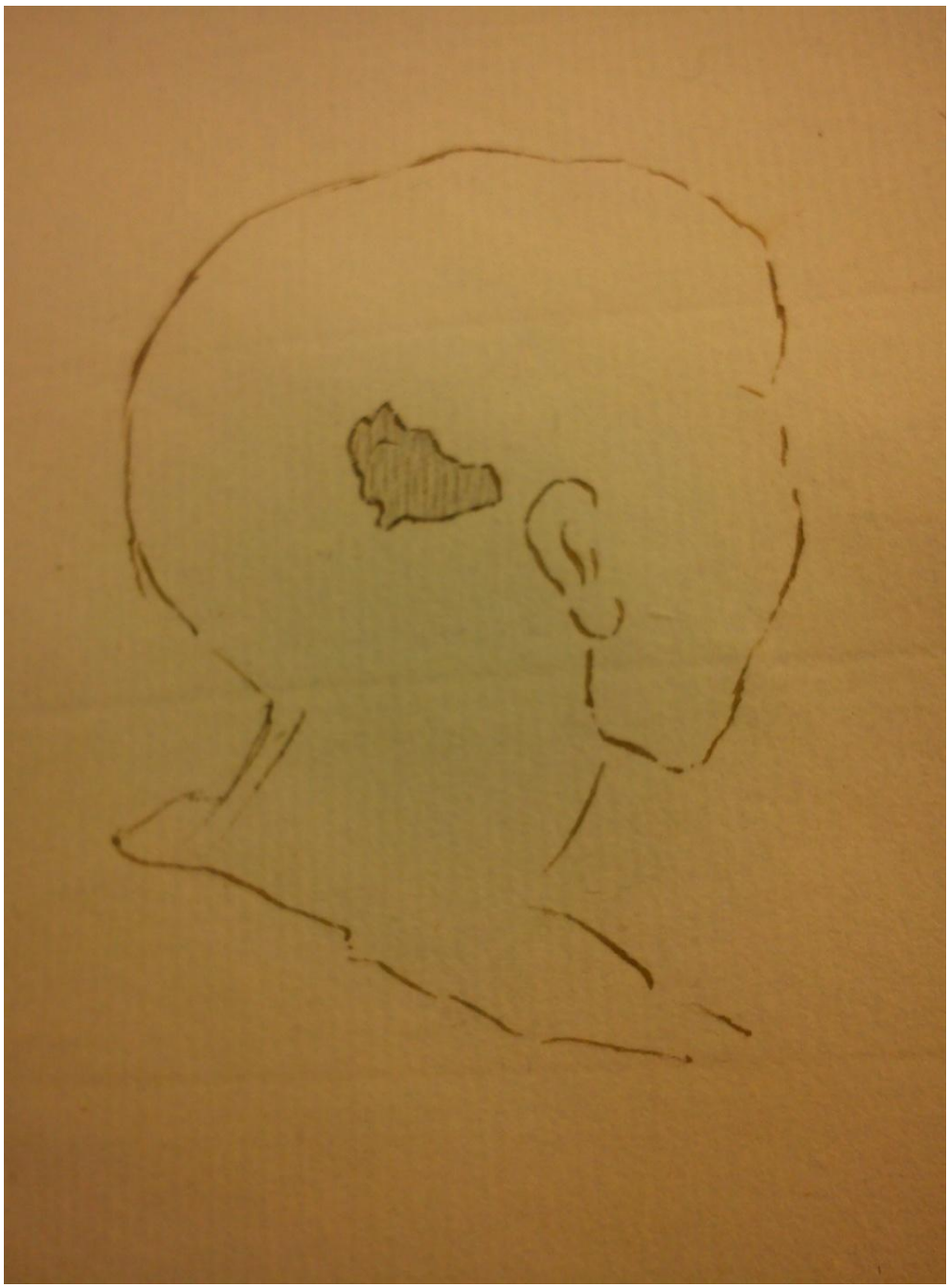


Figure 110: J. Thomson, *James Young*, 1815, pen and ink on paper, *Sketches*, f. 24.

Figure 111: S. Nicholls, Untitled [*Margaret White*], 1740, line engraving, from W. Cheselden, *Anatomy of the Human Body*, pl. 40.

Figure 112: S. Nicholls, Untitled [J*ohn Heysham*], 1740, line engraving, from W. Cheselden, *Anatomy of the Human Body*, pl. 39.

Figure 113: M. Burghers, *Elizabeth Hopkins*, c. 1700, line engraving, 72 x 63mm.

Figure 114: M. Burghers, *Mrs John Webb*, c. 1700, line engraving, 72 x 63mm.

Figure 115: J. Rogers, after R. E. Drummond, *Miss Hannah Thatcher*, 1823, stipple, 219 x 141mm.

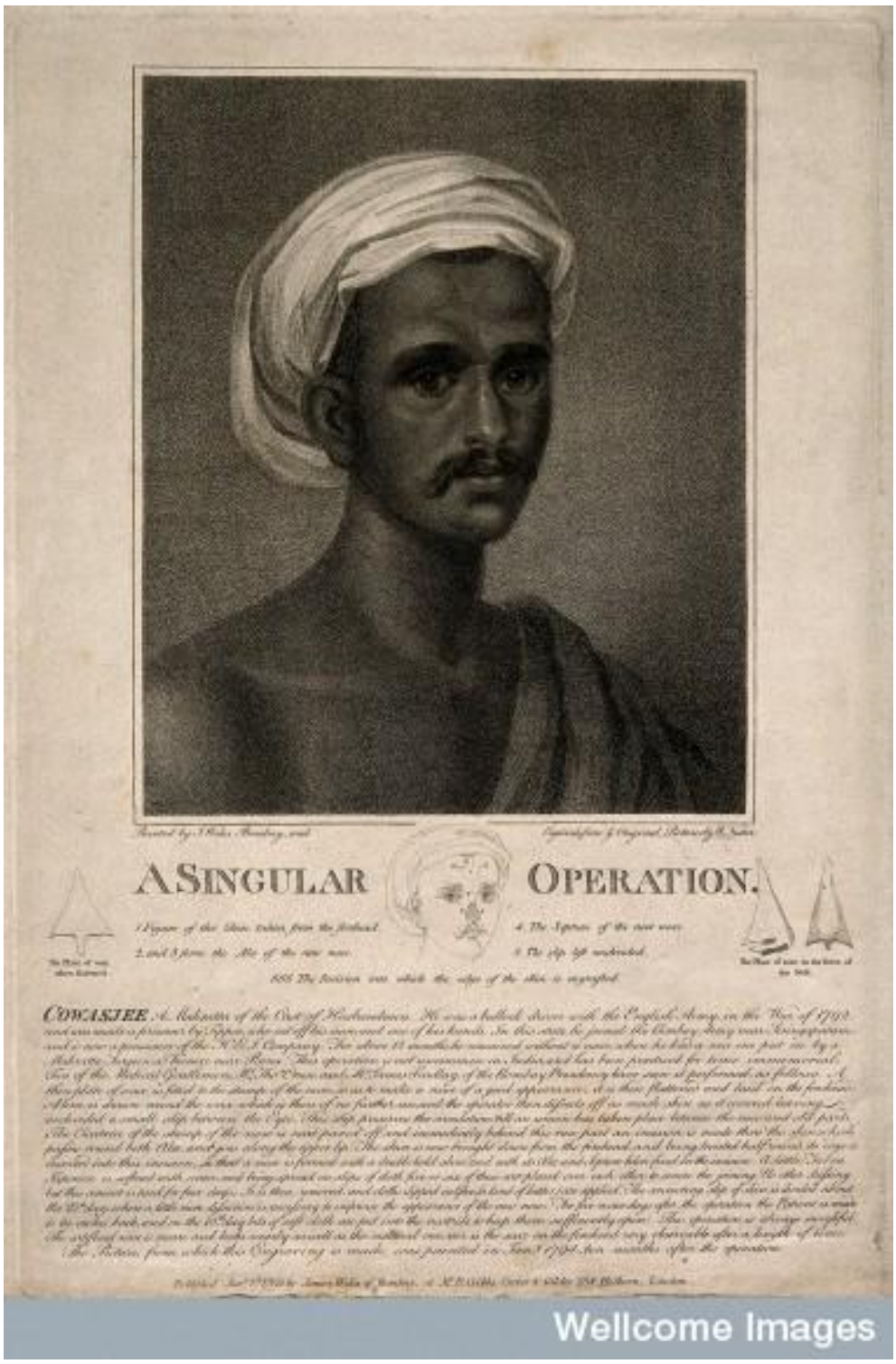
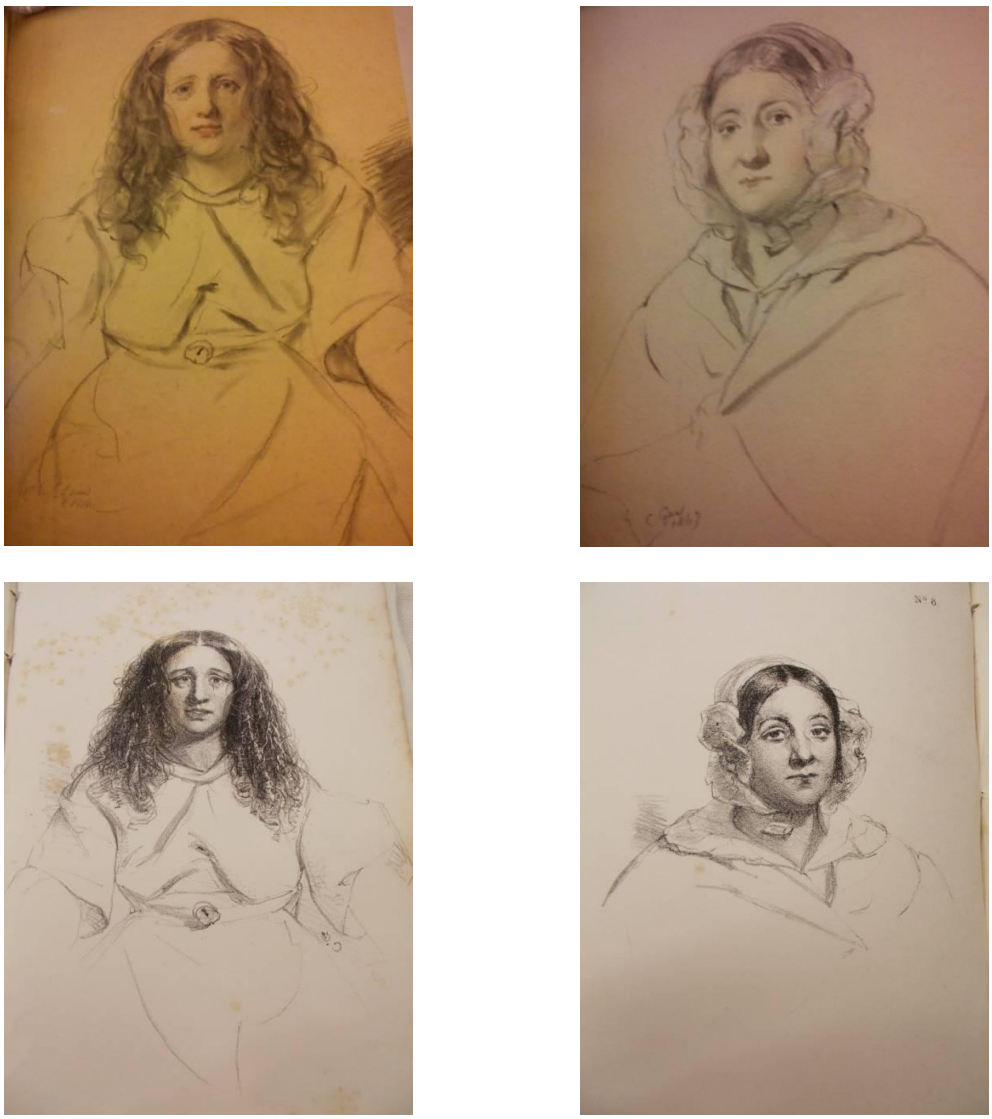


Figure 116: J. Wales, after W. Nutter, *A Singular Operation*, 1795, stipple, 364 x 248mm.

Figure 117: Leonard, after R. W. Bradley, *Elizabeth Powis*, 1845, lithograph, frontispiece to E. Sands Cox, *A Memoir on Amputation at the Hip-Joint*.



Figures 118-121: A. Rochard, *Couser Dinner*, n.d., graphite on paper, MOR/4/34-5, reprinted W. H. Lizars, in A. Morison and T. C. Morison, *Outlines* 1848, pl. 7-8.

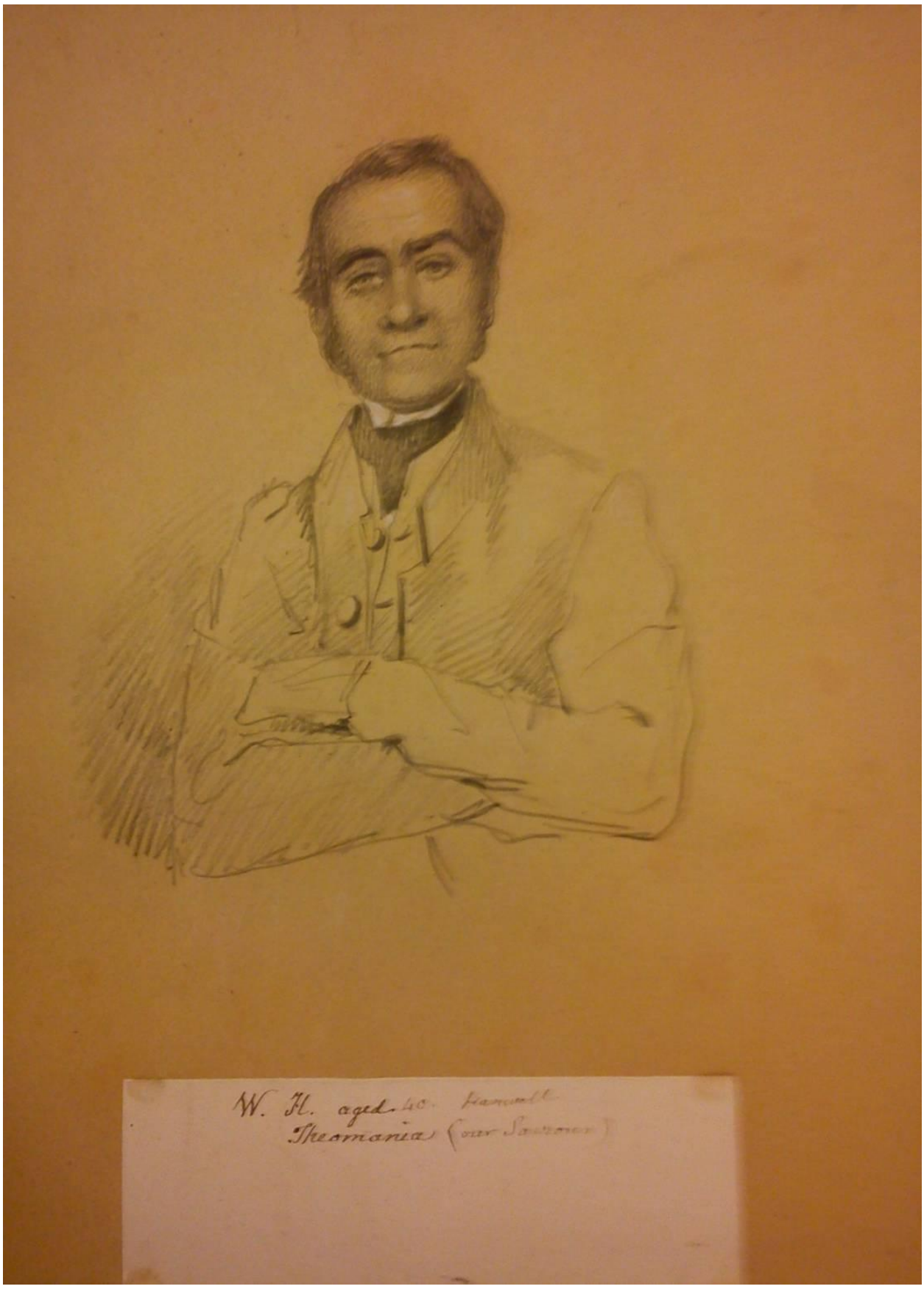


Figure 122: F. Rochard, *W Hanwell*, n.d., graphite on paper, MOR/4/90.

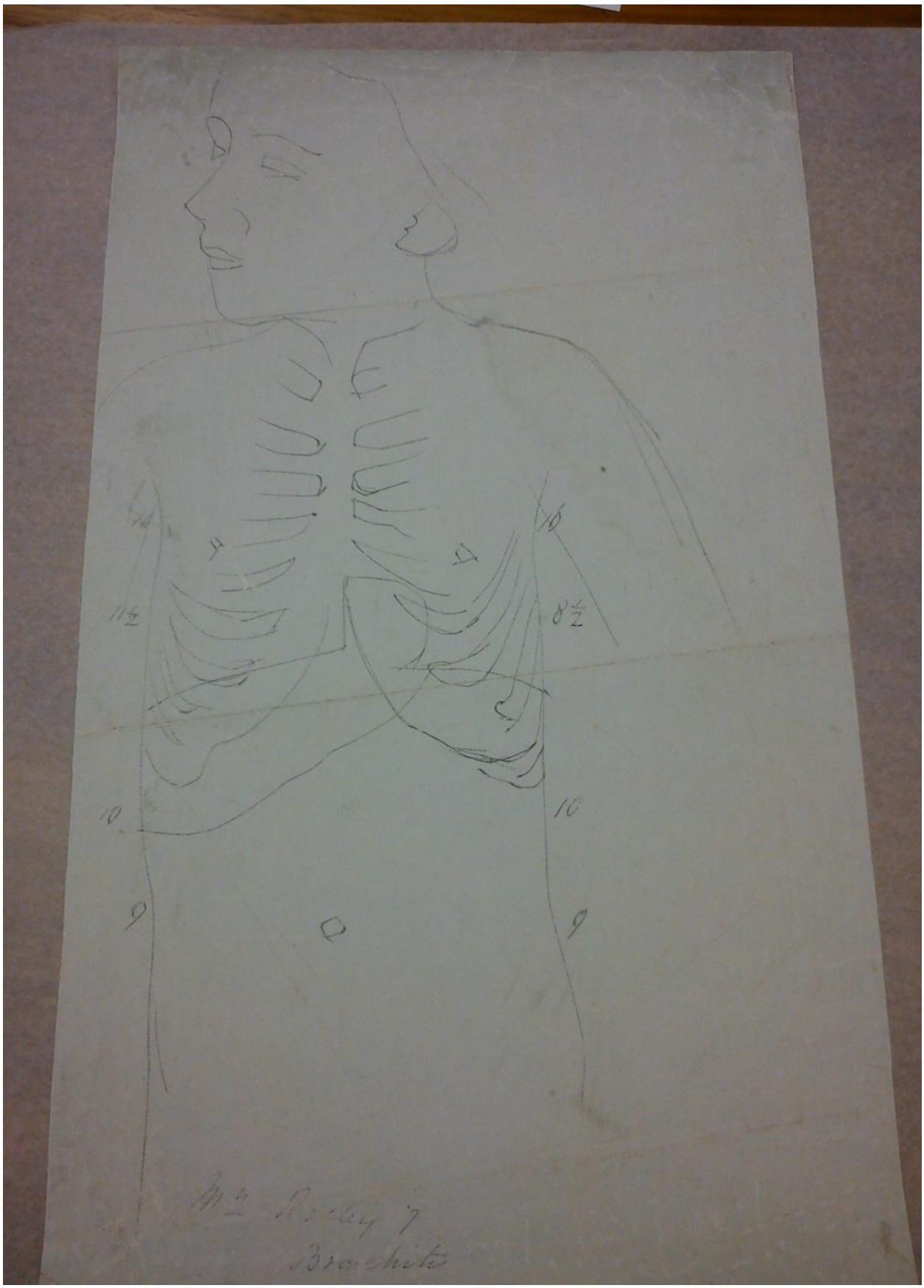


Figure 123: W. Fairland (?), *Mrs Redditch aet. 72 / Emphysema Bronchitis*, n.d., pen on card, 533 x 399mm, RCPL SIBSF/793/122.

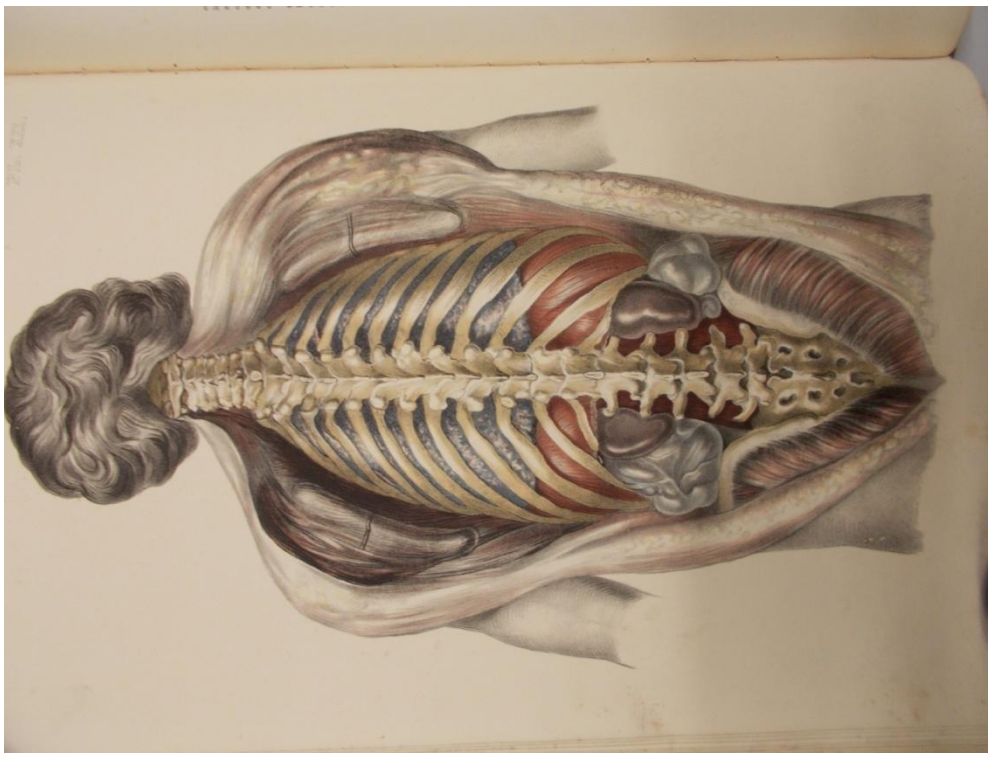


Figure 124: From F. Sibson, *Medical Anatomy*, plate XII.

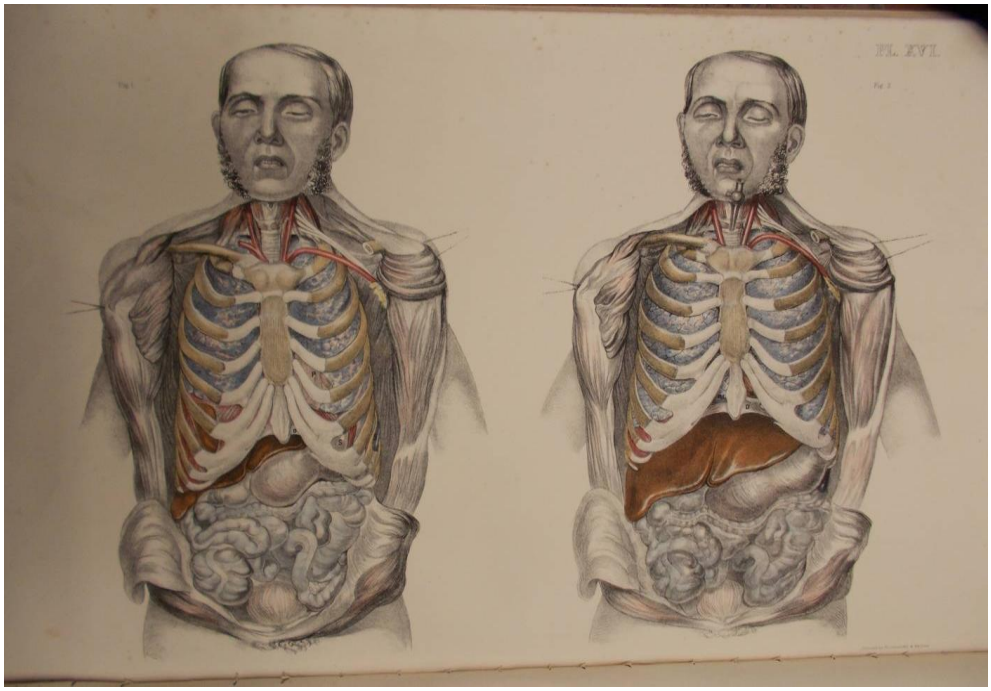


Figure 125: From F. Sibson, *Medical Anatomy*, plate XVI.

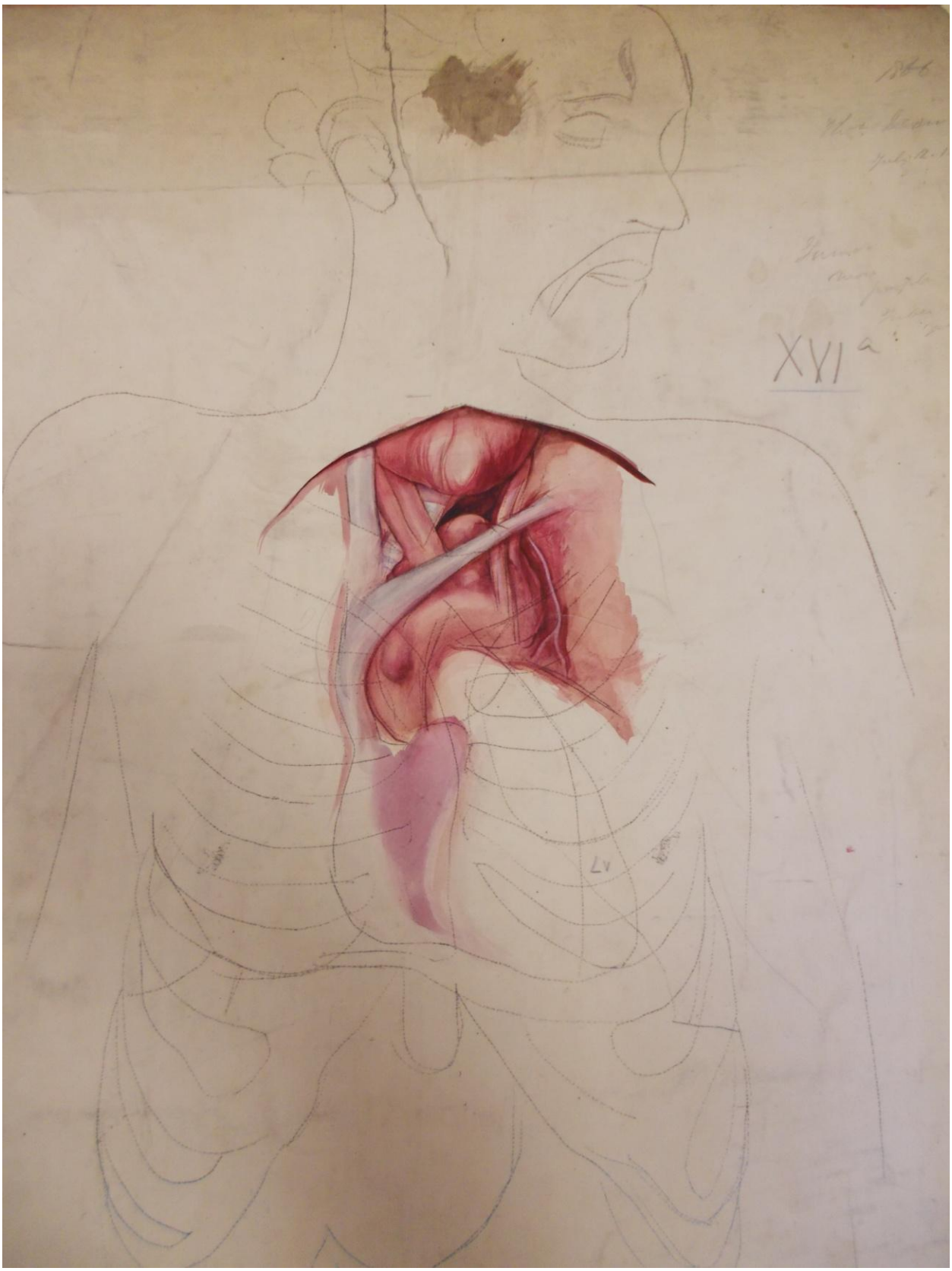


Figure 126: W. Fairland (?), *Untitled* [Thomas Dedin], n.d., pen and watercolour on card, 716 x 526mm (detail), RCPL SIBSF/793/189.

Figure 127: From F. Sibson, *Medical Anatomy*, plate I (detail).

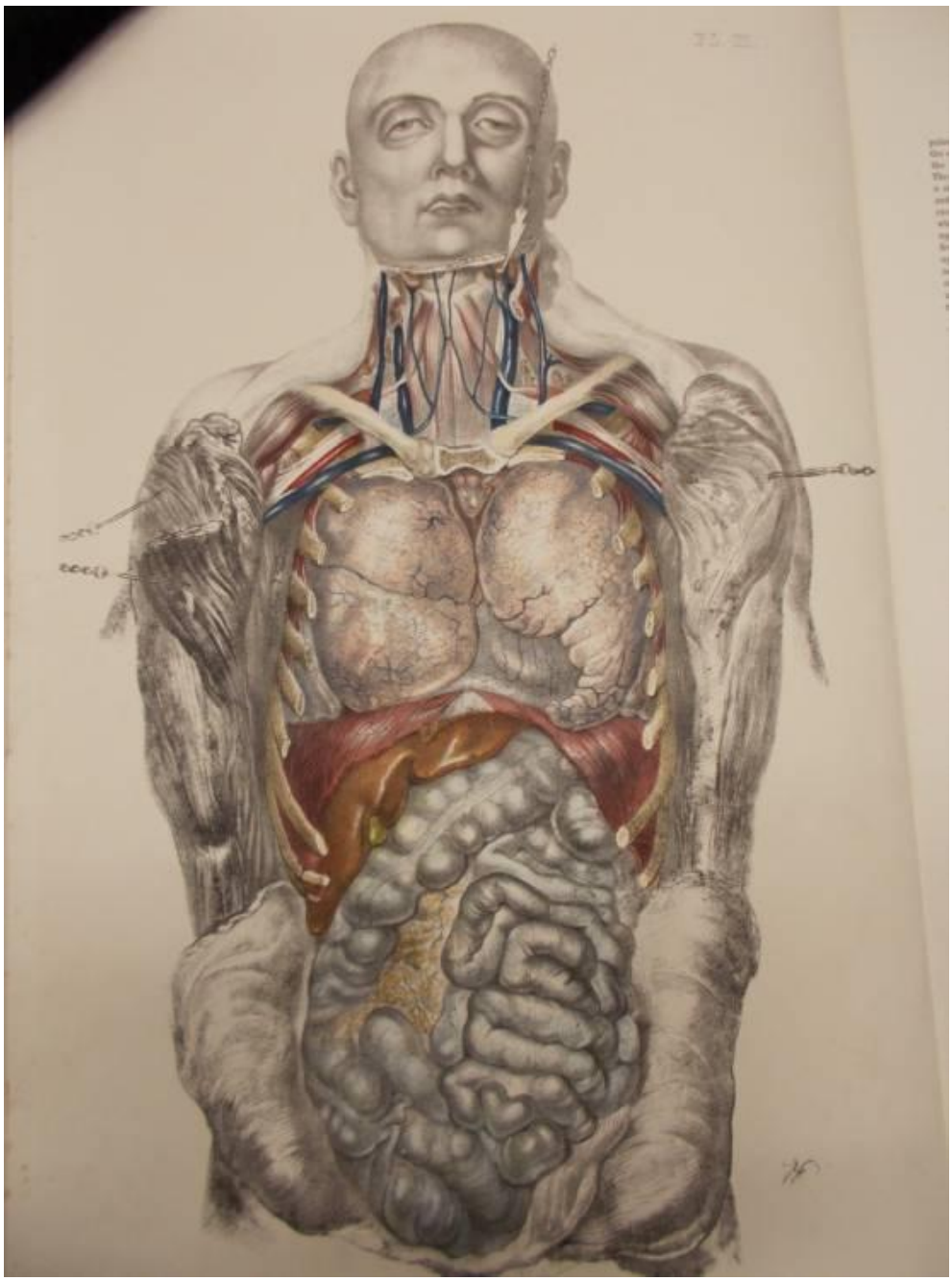


Figure 128: From F. Sibson, *Medical Anatomy*, plate III; and detail

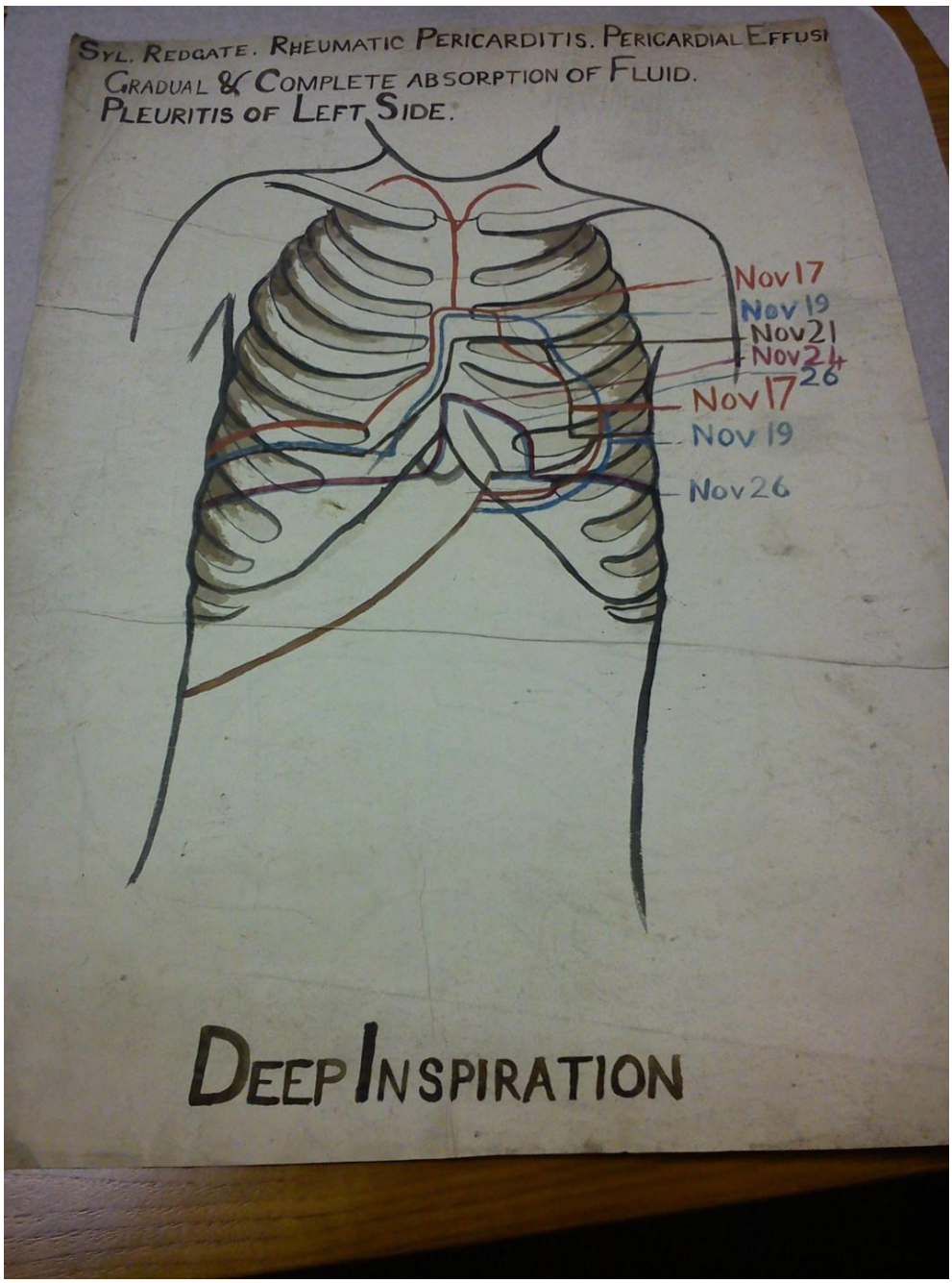


Figure 129: W. Fairland (?), *Syl. Redgate. Rheumatic Pericarditis. Pericardial Effusi[on]/ Gradual & Complete Absorption of Fluid*, n.d., watercolour on card, 705 x 517mm, RCPL SIBSF/793/217.

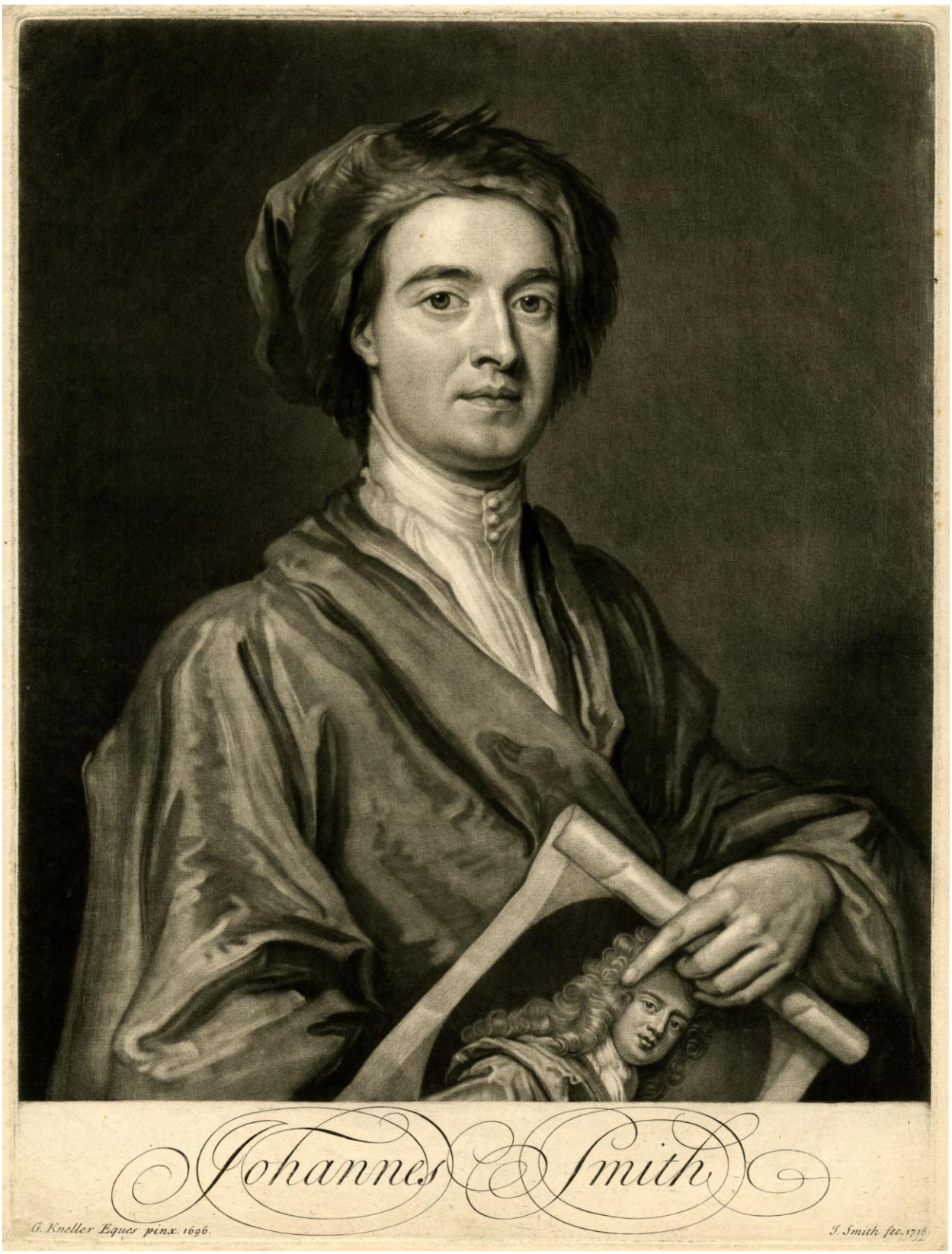


Figure 130: J. Smith, after G. Kneller, *Johannes Smith*, 1716, mezzotint, 340 x 255mm.

Figure 131: W. Allan, *William Hey, with a child patient*, [and Lady Harewood] 1816, oil on canvas.

Figure 132: J. Preud'homme, *Douglas, 8th Duke Hamilton, on His Grand Tour with his Physician Dr John Moore and the Latter's Son, John*, 1773, oil on canvas, 970 x 750mm.

Figure 133: J. Richardson, *Alexander Pope*, 1738, oil on canvas, 441 x 365mm.

Figure 134: J. Richardson, *Martin Folkes*, 1735, graphite on vellum, 179 x 134mm.

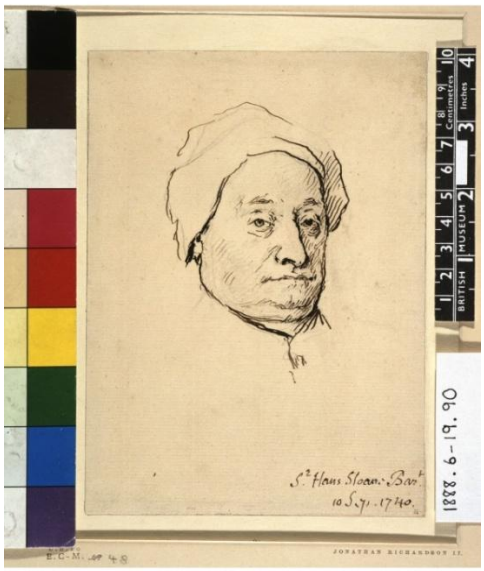


Figure 135: J. Richardson, *Hans Sloane*, 1740, pen and ink, over graphite, on vellum, 177 x 130mm.

Figure 136: J. Richardson, *Alexander Pope*, 1733/4, graphite on vellum, 168 x 136mm.

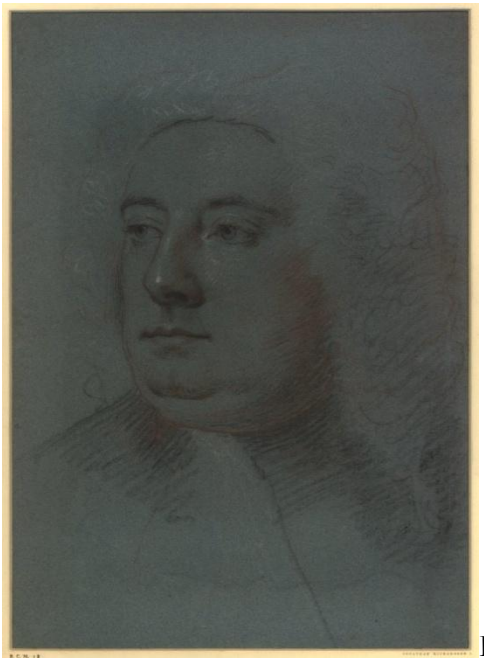


Figure 137: J. Richardson, *William Cheselden*, 1735, pen and ink, over graphite, on vellum, 144 x 90mm.

Figure 138: J.-A. Dassier, *Alexander Pope / Poeta Anglus MDCCXLI*, 1741, bronze, 55mm.